Ontario

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
March 22, 24, 2011	2011-145-2595-22Mar143433 2011-155-2595-22Mar111205	Complaint L-00143

Licensee/Titulaire
Caressant-Care Nursing and Retirement Homes Limited, 264 Norwich Avenue, Woodstock, ON N4S 3V9

Long-Term Care Home/Foyer de soins de longue durée
Caressant Care Harriston, 24 Louise Street, P.O. Box 520, Harriston,ON N0G 1Z0

Name of Inspector(s)/Nom de l'inspecteur(s)
Karin Mussart, #145 and Sharon Perry, #155

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection relating to maintenance, laundry, product supply concerns, bathing and resident care issues.

During the course of the inspection, the inspector(s) spoke with: Administrator; Corporate Environmental Consultant, Executive Director, Director of Care, Food Service Manager, Resident Care Coordinator, Registered Nurse, Registered Practical Nurses, Personal Support Workers (PSW), and Residents.

During the course of the inspection, the inspector(s): Toured resident rooms; viewed tub rooms; checked linen supply and conditions of linen on floor; observed interior damage from leaking roof; reviewed policy and procedures relating to Facility Interior and Repair and Disposal of Linens; observed lunch dining room service; observed afternoon snack cart; and reviewed Resident clinical records.

The following Inspection Protocols were used during this inspection: Accommodation Services- Laundry and Maintenance; Dining Observation; and Snack Observation.

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

6 WN
4 VPC

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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 suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s. 15(2)(c)

(2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

Findings:

1. Observed in at least 3 resident rooms where the walls, doors and doorframes were damaged,
2. Observed in at least 3 resident rooms where the dresser/bedside tables were damaged on the top surface.
3. Observed in two corridors where the ceiling tiles are bucking, and in some areas stained.

Inspector ID #:	#145

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 maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg. 79/10, s.89(1)(c)

(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,
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.

Findings:

1. Observed in 4 resident rooms that towels and face cloths were stained or were discolored and available for resident use. In one resident room noted that face cloth was torn at the corner.
2. Observed on a linen cart, two worn soaker pads available for use and in 2 other rooms noted worn soaker pads on beds.
3. In three resident rooms, observed that the top sheet on the beds had holes in them.

Inspector ID #:	#145

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 linen is kept clean and sanitary and maintained in a good state of repair free from stains, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg. 79/10, s.71(4)
The licensee shall ensure that the planned menu items are offered and available at each meal and snack.

Findings:

1. On March 22, 2011 the 2 pm snack cart was to have bran crunch cookies for all diets as per planned menu. The snack cart did not have any bran crunch cookies available for residents on diets other than pureed diet.

Inspector ID #:	155

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 planned menu items are available at snack, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg. 79/10, s.73(2)(a)(b)
The Licensee shall ensure that,

(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and
(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.

Findings:

1. On March 22, 2011 at 1210 to 1225 hours there was only one staff in the Memory Lane dining room with 9 residents. The staff was seated feeding residents. At times during the meal the staff stood up and reached across the table to assist another resident.
2. On March 24, 2011 at lunch two residents were being fed by a staff member. This staff member would leave their table to assist two other residents at another table with feeding.
3. On March 22, 2011 at 1210 hours in Memory Lane dining room an individual resident was served their meal. This individual resident was not offered any assistance with their meal from 1210 to 1235
4. On March 24, 2011 in Memory Lane dining room an individual resident was served her food at 1200 hours with no assistance until 1206 hours.
5. On March 24, 2011 at 1223 hours two residents were served their meal and did not have any staff at the table to provide assistance.

Inspector ID #:	155

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 person simultaneously assists more than two residents who need total assistance with eating or drinking; and 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, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg. 79/10, s.129(1)(a)(ii)
(1)Every licensee of a long term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(ii) that is secure and locked

Findings:

1. On March 22, 2011 at 1305 hours a care cart was left in a resident room. On this cart was a prescription cream belonging to an individual resident.

Inspector ID #:	155

WN #6: The Licensee has failed to comply with O.Reg. 79/10, s.229(4)
Every licensee of a long-term care home shall ensure that the infection prevention and control program required under subsection 86(1) of the Act complies with the requirements of this section.
(4)The licensee shall ensure that all staff participate in the implementation of the program.

Findings:

1. On March 22, 2011 at 1305 hours a care cart was left in resident room that contained an uncovered toothbrush and unlabelled petroleum jelly, toothpaste, mouthwash and barrier cream.

Inspector ID #:	155

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). April 29, 2011