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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 13, 2015	2015_381592_0021	O-002109-15	Resident Quality Inspection

Licensee/Titulaire de permis

CITY OF OTTAWA
Long Term Care Branch 275 Perrier Avenue OTTAWA ON K1L 5C6

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

CENTRE D'ACCUEIL CHAMPLAIN
275 PERRIER STREET VANIER ON K1L 5C6

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

MELANIE SARRAZIN (592), LINDA HARKINS (126), LISA KLUKE (547)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 24, 25, 26, 27, 28, 31 and September 2, 3, 4, 2015

One Complaint inspection was conducted concurrently for Log#:O-002577-15

During the course of the inspection, the inspector(s) spoke with The Administrator, the Director of Care, the Coordinator of Resident Care, Dietitian (RD), Manager of Food Services, Manager of Environmental Services, several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW), several Housekeeping staff (Hkp), several Dietary staff, the President of the Resident Council, the President of the Family Council, several Residents and several Family members

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

10 WN(s)
6 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 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. On September 04, 2015, inspector #592 was in her way to Resident #039's room to conduct an interview with a staff member. Inspector #592 observed the door of Resident #039 who was left half opened and upon the request of PSW S#129, inspector #592 entered in the Resident's room. Inspector #592 observed Resident #039 lying in bed while PSW S#103 proceeded to transfer Resident's #039 in his/her wheelchair. While inspector #592 was interviewing both staff members, PSW S#103 started to initiate personal care for Resident #039 and disrobe resident #039 upper body exposing his/her chest with inspector's presence. Inspector #592 left the room in order for Resident #039 to be afforded privacy.

On September 04, 2015, in an interview with PSW S#129, she told inspector #592 that residents are always provided with privacy but for Resident #039 they went ahead and started the personal care with the inspector's presence as they would do with family members.

On September 04, 2015, in an interview with PSW S#103, she indicated that she always give her care in privacy and does not recall that resident #039 was disrobe this morning in front of Inspector #592.

On September 04, 2015, in an interview with the Coordinator of Resident Care, she indicated that residents personal care are to be provided in private and that Ministry of Health were not considered family members but visitors, therefore resident should of not been disrobe in front of Nurse inspector. [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 to ensure that all resident's be afforded privacy in treatment and in caring for his or her personal needs., to be implemented voluntarily.

WN #2: 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 has failed to ensure that the care set out in the plan of care is provided to Resident #042 regarding dietary menu.

On August 24, 2015, while conducting the dining inspection protocol, Inspector #547 observed Resident #042's nosey cup to be half full of pea soup. Resident #042 was further observed being fed chocolate mousse.

Upon review of the Dietary Kardex, it was noted that Resident #042's Dietary Kardex specified that the Resident is lactose restricted, and to avoid puddings. Upon further review, the resident's special instructions on the Kardex also indicated that Resident #042 is not to have cream soups or pea soup. Inspector #547 reviewed Resident #042's plan of care related to choking risk, which indicated that the resident is to avoid lactose and chocolate as these thicken the resident's secretions, and creates a residual film.

On August 24, 2015, Dietary Aide #123 confirmed with Inspector #547, that Resident #042 was served pea soup, and that she had not consulted with the resident's Dietary Kardex. The Dietary aide further stated that she was unaware that Resident #042 could not have dairy products. Inspector #547 requested information from Dietary aide #123 on how staff prepared residents food choices who could not respond to choices offered. Dietary aide #123 indicated that they follow the resident's Dietary Kardex prepared by the dietary supervisor. [s. 6. (7)]

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 care set out in the plan of care regarding dietary choices is provided to Resident #042 as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that Resident may be restrained by a physical device if the restraining of the resident is included in the resident's plan of care.

On September 03, 2015, at 9:00, Resident #010 was observed in his/her room, in his/her wheelchair with a restraint physical device (front seat belt) on. Resident was agitated and was trying to transfer himself/herself to his/her bed. Upon asking Resident #010 if he/she was able to release his/her seat belt, the resident indicated that he/she did not know how the belt was working and was still attempting to release his/her seat belt with no success during the time of the interview.

On September 03, 2015, PSW #121, #124 and #125, told inspector #592 that Resident #010 was able to release his/her seat belt whenever he/she wanted and therefore, the belt was not considered a restraint. They further indicated that the belt was in place to prevent the resident from falling.

On August 03, 2015, it is indicating in the progress notes that Resident #010 is to use a seat belt following a recent fall, when he/she is using his/her wheelchair and that the resident is able to release the seat belt. Progress notes further indicated that the seat belt is applied as a reminder to the resident to not try to get up on his/her own. Upon review of the Resident's Health care Records, it is noted that Resident #010 is diagnosed with Dementia with poor short and long term memory. No documentation was found in the plan of care for the use of a physical device for Resident #010. No physician order, no consent, no monitoring and no assessments were found in Resident #010 who is using a physical device.

On September 03, 2015, on two different occasions, PSW #125 and RN #126, asked Resident #010 to remove his/her seat belt, but the Resident was not able without some cueing and assistance from the Nursing staff.

On September 03, 2015, RPN #106, told inspector #592 that if a Resident is not capable

to remove a seat belt, the seat belt will be considered a physical restraint which would need a doctor's order and monitoring to be in place. RPN #106 told inspector #592 that Resident #010 had several falls and a seat belt was applied for the prevention of fall. RPN #106 was unable to find any doctor's orders, any consent or monitoring documentation for the use of a restraint for Resident #010.

On September 04, 2015, in an interview with the Coordinator of Resident Care, she indicated to Inspector #592 that if residents were not capable to release their physical devices without the assistance and cueing from the staff that physical device was considered a restraint. She further added that a physician order would be needed and a consent from the Resident's family. In addition she indicated that appropriate monitoring and assessments of the residents should be done and that residents who are capable to release their physical devices were reassessed upon a change in condition or as needed. [s. 31. (1)]

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 #010 physical device will be identified in his/her plan of care and meeting all the requirements when using a physical device, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

On August 27, 2015, Inspector #547 observed a dressing to Resident's #034 specified body part. Resident #034 indicated that the skin tear occurred several weeks ago while getting onto his/her wheelchair. Resident #034 further told inspector #547 that since that occurrence, he/she went on two occasions at the nurses station requesting Registered staff members to change his/her dressing which was provided.

On August 31, 2015, Inspector #547 interviewed RPN #102 and RPN #109 who both indicated that dressings are being monitored on the Medication Administration Records (MAR) for Registered nursing staff too change dressing as required. RPN #102 reviewed the resident's MAR, and no indication of any skin tear, or dressing were required for Resident #034 on file. No skin assessments, skin monitoring or any documentation were found for the two occasions where Resident #034 asked the Registered staff to have his/her dressing change at the nurses desk.

On that same day, RPN #102 assessed Resident's #034 skin integrity, and noted a dressing was in fact in place on the Resident, and that the Resident did have an open area over a bruise to his/her specified body part that remained not healed. [s. 50. (2) (b) (ii)]

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 exhibiting skin integrity, receive immediate treatment and interventions to promote healing and prevent infection, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart, that is secure and locked.

1.On August 26, 2015, Inspector #547 observed in Resident's #032 bathroom, 9 prescribed medications in a bag:

Two additional containers of prescribed creams were also located beside Resident #032 bed.

Resident #032 indicated to Inspector #547 that staff were applying these creams and that staff always kept them in his/her room.

On August 26, 2015, during an interview with the administrator, she indicated that Resident #032's medications did not belong to the home's pharmacy and she was not aware that these medications were in the Resident's room.

2. On August 28, 2015, Inspector #592 observed in Resident #036 shared bathroom 3 prescribed topical creams and 1 prescribed medication was also located on the side table of Resident #036.

On August 28, 2015, RPN #102 told Inspector #592 that no creams were to be left in any resident's room and went to remove the prescribed medications from the Resident's room.

3. On August 27, 2015, Inspector #592 observed in Resident #013 bathroom, one prescribed cream left in a plastic basket.

On August 27, 2015 RPN #102 indicated that the cream for Resident #013 was discontinued and that no creams were to be left in the room.

On August 28, 2015, The Administrator indicated to Inspector #592, that no topical creams and medications should be left in resident's room unless they are kept secure and locked.

4. Inspector #547 noted during dining observation of the second floor dining room on August 24, 2015 that the medication carts located outside the main floor dining room for this secure unit to be unlocked and not attended by any registered nursing staff for a two minute period while residents were leaving the dining room after the lunch meal.

RPN #102 returned and indicated to Inspector #547 that the medication cart should have been locked and thought there was an automatic locking mechanism to this cart once the drawers closed.

Upon an interview with RPN #102, it was noted that there is a delay in the automatic locking mechanism of two minutes before the cart becomes locked automatically.

RN #101 who was present during the interview, indicated that the carts are also equipped with a manual locking mechanism on the side of the cart by pressing a button, to override the automatic locking mechanism and should be used before walking away from the medication cart if it has not locked automatically.

On August 25, 2015 Inspector #547 observed the medication cart for the East wing of the Fifth floor to not be locked or attended during the lunch meal.

On August 26, 2015 Inspector #547 noted medication cart on the fifth floor to be unlocked and unattended by any registered nursing staff member located outside the

resident's dining room as resident's were entering the dining room for the lunch meal. RN #106 returned to the cart, and indicated that she did not lock the cart when she walked away.

On August 31, 2015 Inspector #547 observed in front of the fifth floor dining room, a bottle of prescribed Euro-Lac 667mg/ml oral liquid sitting on top of a locked medication cart unattended by any registered nursing staff. Resident #031 was observed,standing next to the medication cart. Inspector #547 waited until RPN #115 returned to the cart and told inspector #547 that she was supposed to lock up this bottle in the bottom of the medication cart before stepping away.

Inspector #547 interviewed the Director of Care who stated that she had spoken to RPN #115 last week about this same situation, and that medications are to be locked in the medication cart before stepping away from the cart.

On September 3, 2015 Inspector #547 observed a medication cart for the West wing on the Fifth floor to be unlocked and unattended by any registered nursing staff. A second cart was also noted next to this medication cart for the East wing, that was locked, however a bottle of Euro Lac 667mg/ml oral liquid that was full sitting on top of the medication cart without any cap on the bottle also unattended.

The Coordinator of Resident Care indicated that if the medication drawers are not closed completely, the medication cart will not lock automatically. She further indicated the home's expectation is that staff lock the medication carts manually before leaving the area as the locking mechanism on these carts are delayed. The medication sitting on top of the cart, was also noted, and indicated that RPN #115 is aware to lock up medication in the medication carts when unattended by any Registered Nursing staff. [s. 129. (1) (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 drugs are stored in an area or a medication cart that is secure and locked, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident administer a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

On August 28, 2015, Inspector #592 observed in Resident #036's side table one prescribed medication inhaler

During a review of the Physician orders dated on August 25, 2015, no indication for the approved self-administration for the inhaler was found.

On August 28, 2015 during an interview with RPN #102, she told inspector #592 that Resident #036 was self-administrating his/her inhaler and other prescribed medications were to be administrated by the Registered staff. RPN #102 was not able to found any indications in the resident's chart for the authorization of self-administration for Resident #036. She further indicated that the home's process is to have the resident assessed closely by a Registered Staff and then, if resident is meeting the requirements, the physician will be made aware and asked for an approval. No documentation was found of the Resident #036 being assessed for resident self administration.

On August 28, 2015 during an interview with the Administrator, she was not aware that Resident #036 had medication in his/her room and was self administrating without the approval by the prescriber. [s. 131. (5)]

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 no resident administered a drug to himself/herself unless it has been approved by the prescriber, to be implemented voluntarily.

WN #7: 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. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails.

On August 25, 2015, Inspector #547 interviewed a family member of Resident #008 who indicated that they had to pay for foot care and shaving.

On August 28, 2015, Inspector #547 interviewed Resident #034 who indicated that he/she is paying for his/her foot care for himself/herself and for his/her spouse who also resides at the home.

On August 27, 2015, Inspector #126, interviewed Resident #028 who indicated that he/she lived in the home since 2012 and was paying for foot care as it was not offered to him/her to have his/her toe nails cut during the weekly baths.

On August 27, 2015, Inspector #126, interviewed PSW #116 who indicated that she does not cut toe nails and that it was done by a person from the outside.

On August 31, 2015, Inspector #126 interviewed PSW #103 who indicated that she does not cut toe nails and that it was done by a person from the outside.

The foot care Binder was reviewed and it was indicated that Resident #008, #028 and #034 were paying for foot care.

Discussion with several Registered Nurses (RN) and Registered Practical Nurse(RPN) who indicated that advanced "specialized" foot care is offered to residents that are diabetic, have thick nails or other type of problems and that the PSW's are expected to be giving basic nail care to hands and foot. RN and RPN told inspector #126 that Resident #008, #028 and #034 were not requiring "specialized" foot care. [s. 35. (1)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a weight monitoring system to measure and record each resident's body mass index and height on admission and annually thereafter.

On August 24, 25 and 26, 2015, it was noted during the completion of the census review that the height were taken on admission only and was not redone on an annual basis.

On August 26, 2015, Inspector #126 interviewed with RPN #102 regarding the height of the residents. RPN #102 indicated that heights were taken on admission only. It was noted that several residents used for the Resident Quality Inspection Sample were admitted to the home in 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013 and 2014 and did not have their heights taken on an annual basis.

On August 28, 2015, Inspector #126 interviewed Registered Dietitian(RD) who indicated that she was aware that the home were not doing heights annually. [s. 68. (2) (e) (ii)]

WN #9: 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 has failed to ensure that planned menu items are offered and available at each meal for residents.

On August 24, 2015 the planned puree menu was identified as the following:
Italian style cheese macaroni and crushed tomatoes or Roast turkey, Marsan bread and caesar salad and dessert was lemon squares or strawberries.
Items offered for residents with puree diet textures was Italian style cheese macaroni and crushed tomatoes, Marsan bread, or caesar salad.

The planned minced menu was the same however residents were offered a minced turkey sandwich instead of the two items separately for puree.

The Dietary aide serving the meal indicated that residents receiving the minced and puree choices do not care for the cold option, so they do not offer it as first choice. If the resident does not want to eat the first tried menu item, they will try the other option. The Dietary aide indicated that he had not served any minced or pureed turkey sandwich for this lunch meal today. Items available for residents with puree or minced diet textures did not include lemon squares for dessert. The minced strawberries was also not available and residents were offered a substitute of chocolate mousse and strawberry puree.

1. Resident #044 received a plate of pasta/potatoes/tomatoes while the two other residents at his/her table received sandwich and salad. Resident #044 asked what he/she was just served, and when it was explained to him/her, the resident indicated that he/she does not like tomatoes and was not offered the sandwich and salad choice. Resident #044 then received his/her choice.

2. Resident #006 received pasta and tomatoes and potatoes indicated that he/she did not like tomatoes, and would have preferred a sandwich with a fresh salad, but this was never offered to him/her.

Residents at this meal were not all offered a choice of meal, or shown any meal plate to identify choices available. [s. 71. (4)]

WN #10: 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 has failed to ensure that staff participate in the implementation of the infection prevention and control program by having personal care items unlabeled that were located in common use areas such as shower or tub rooms in the home or tub washed out after resident use.

On August 24, 2015, Inspector #547 conducted a tour of the home and observed Antipersperant/deodorant bottles not labeled located in every tub or shower rooms on every nursing unit. The Men's shower room on the fifth floor also had an unlabeled bar of soap and container. The Woman's shower room on the second floor had a blue disposable razor with significant hair in the blade noted on the counter next to the sink.

On August 26, 2015 Inspector #547 noticed the tub inside the shared tub room on the East wing of the fifth floor had dirty yellow matter up the inside of the tub for about three inches from the bottom that is removable with Inspector #547 finger at 11:30. The tub chair was also noted to be dirty to the seat as well as the seat belt was noted to have white matter and an odor. Inspector #547 returned to the same tub room at 13:30 and interviewed PSW's #107 and #108 inside the East Wing tub room and both staff members indicated that the tub was soiled and had not been washed with the brush and the disinfection solution as required before the next resident from that morning.

On September 2, 2015 Inspector #547 observed a container of infazinc with no cap that had been used was still located on the top shelf behind the toilet, and a roll on antipersperants as well as a white hair brush located in the sink for the second floor woman's shower room.

Inspector #547 interviewed the infection control lead for the home who indicated that the residents personal items should all have a label. All personal items are labeled with a label made by the home with name and room number that they are provided upon their admission in the home. PSW's are given the labels to add to all personal care items and can be printed at any time, and kept stored in every resident room closet in a folder. Resident's items are to be placed in a little basket with their name, and brought to the bath or shower room. No personal items are to be left in the tub or shower rooms. Once a bath or shower is done, the staff are to clean the tub or shower, and bring all the resident's items back to their basket and then to their room. [s. 229. (4)]

Issued on this 23rd day of October, 2015

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

Original report signed by the inspector.