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

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Jan 24, 2014	2014_225126_0001	O-000019-14	Resident Quality Inspection

Licensee/Titulaire de permis

EXTENDICARE NORTHEASTERN ONTARIO INC
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

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

EXTENDICARE STARWOOD
114 STARWOOD ROAD, NEPEAN, ON, K2G-3N5

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

LINDA HARKINS (126), AMANDA NIXON (148), COLETTE ASSELIN (134), JESSICA LAPENSEE (133)

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): January 13, 14, 15, 16, 17, 20, 21, 22, 2014

During the course of the inspection, the inspector(s) spoke with Administrator, the Director of Care, the Assistant Director of Care, the Infection Control Practitioner, Corporate Representatives, several Registered Nursing staff, several Personal Home Support Workers, the Nutritional Manager, Dietary Aids and Cook, the interim Lead for Housekeeping and Laundry services, one of the home maintenance worker, on member of the housekeeping services, the Nursing clerk, the Resident Council President, the Family Council President, several Residents and family members.

During the course of the inspection, the inspector(s) reviewed residents health care records, several policies: Resident Care Manual Continuum of care (RESI-04-03-01), Care Planning (#03-01-02), Food holding and distribution (DIET -07-01-02), Point of service food temperatures (DIET-07-01-03) , observed care and services provided to residents.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Sufficient Staffing

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. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg. 79/10, s.13, where by the licensee did not ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy.

On January 13, 2014, an identified resident's room was observed to be equipped with a mechanical ceiling lift. The mechanical ceiling lift tract, that runs the length of the room, prohibits full closure of the privacy curtains and there is not enough slack in the

curtains installed to provide for resident privacy between the resident beds at the intersection of the ceiling tract and curtains. On January 16, 2014, six resident rooms, including the noted resident room above, were observed on 2nd Floor to have insufficient privacy curtains to provide privacy. Each of the six rooms were equipped with a mechanical ceiling lift, the mechanical ceiling lift tract, that runs to length of the room, prohibits full closure of the privacy curtains and there is not enough slack in the curtains installed to provide for resident privacy between the resident beds. Inspector #148 noted that the privacy curtains in several other rooms that are equipped with a mechanical ceiling lift, have a Velcro strip that assist to ensure privacy around the ceiling tract.

On January 14, 2014, an identified resident's room was observed to have a missing privacy curtain around bed 1 which resulted in insufficient privacy curtains to ensure resident privacy. On January 16, 2014, four resident rooms, including the noted resident room above, were observed on 2nd Floor to have one missing privacy curtain in each room, which lead to insufficient privacy curtains to provide resident privacy. The home’s DOC accompanied the inspector and observed two of the rooms and observed a privacy curtain missing in each room. On January 17, 2014, the same four resident rooms were observed by Inspector #148; the inspector observed that the missing curtain for one room had been replaced, however, three of the rooms continued to have one missing privacy curtain, which resulted in insufficient privacy curtains to ensure resident privacy.

On January 16, 2014, two identified resident's rooms were observed to have curtains too short in length which did not run the entire length of the curtain ceiling tract resulting in insufficient curtains to provide for resident privacy. Specifically the privacy curtain in a specific room covered less than half of the span of the ceiling tract and did not provide for full privacy between the two resident beds. The home’s DOC accompanied the inspector and observed both rooms. On January 17, 2014 the same two rooms were observed by Inspector #148; the inspector observed that the privacy curtain in a room had been replaced with one curtain that provided for sufficient privacy, however, the other room continued to have insufficient privacy curtains to ensure resident privacy.

On January 16, 2014, two identified resident's rooms were observed for sufficient privacy curtains. Inspector #148 noted that in both rooms the privacy curtain between two resident beds spans the entire length of the curtain ceiling tract, however, the ceiling tract is installed several inches off the wall allowing a gap to exist between the

privacy curtain and the wall; this resulted in insufficient privacy curtain to ensure resident privacy between the two beds.

A meeting on January 20, 2014, with two corporate representatives, the home's Administrator and the home's interim Lead for Housekeeping and Laundry Service indicated that the home is currently experiencing a shortage of privacy curtains and this may have contributed to the above observations by the Inspector. The home indicated that they were in the process of auditing all resident rooms, determining the need for privacy curtains and implementing a plan to ensure all resident's have sufficient privacy curtains. [s. 13.]

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 every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy, to be implemented voluntarily.

WN #2: 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:

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; 2007, c. 8, s. 15 (2).
(b) each resident’s linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(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 :

1. The licensee has failed to comply with LTCHA, S.O. 2007, c.8, s. 15. (2) (a), in that the licensee has failed to ensure that the home, furnishings and equipment are kept clean and sanitary, as evidence by the following observations.

On January 13, 2014, Resident #770's privacy curtain was observed to be soiled with

brown stains. The resident indicated that they prefer the curtain not to be drawn because they do not like to see the stain. (134)

On the morning of January 14, 2014 an identified tub room was observed. A white particle board cabinet, storing bottles of bubble bath, 2 hairdryers, an incontinence brief and other miscellaneous items, was noted to have stains, hair and other unidentified debris. In addition there was a baseboard heater located in the toilet of the tub room that was observed to have a thick accumulation of dust along the top. Within the toilet area of the tub room there was a medicine cabinet which was observed to store a comb, hair clips, box of panty liners and used mouth wash. All three shelves of the medicine cabinet were dirty with old debris, hair and stains. There was a curtain that hung between the main area of the tub room and the toilet area. This curtain was noted to be heavily stained. (148)

On January 21, 2014, at 15:15, inspector #133 observed in an identified tub room, a white particle board cabinet with clean towels stored on top. The middle and bottom shelves were dirty with stains, debris, hair and dried matter. On the lower shelf, there was an overturned box of isolation masks with earloops (disposal brand), an unlabeled blue razor with hair in it, an overturned empty denture cup, a rusty safety pin and some spools of thread. (133)

On January 17, 2014, at 12:09, inspector #133 observed in an identified room, that in the washroom, on the top surface of the pipe cover, to the right of the sink, there was an area where the paint had peeled away and upon initial observation, this area appeared rusty. Upon closer observation, the inspector noted that the area was dirty with a thick moist layer of rust colored matter that could be wiped up, with some pressure, with a paper towel. There was no detectable odor. The wall and area around this patch was stained with dried brown colored spots. Following this observation, the inspector and the Assistant Director of Care (ADOC) returned to the washroom together. The ADOC was unsure of what this substance could be. Later that day, the Administrator indicated to the inspector that this matter had been scrubbed away, and it was indeed rust, explaining that the area was being corroded by the alcohol hand sanitizer from the dispenser above the area. (133)

On January 21, 2014, at 10:17, inspector #133 observed that in an identified medication room, clean supplies, such as foley catheters and catheter supplies, oxygen tubing, urine sample bottles, stool sample bottle, rectal tubes, etc, were stored in plastic bins on a lower open shelf area beneath the medication fridge. The outer

edges of these storage bins, and the shelving, was dirty with areas of dried matter of various colors, as is the wall to the left of the medication fridge. During the observation period, the inspector spoke with registered staff member #S123 in that medication room, who indicated that they try to clean one small area at a time, when they can find the time, in an effort to keep this room clean.(133)

Another medication room was observed by inspector #134 on January 20, 2014 at 10:30. The floor was noted to be dirty with debris such as pieces of paper and dirt. The counter top by the medication fridge was covered in a white powder. The fridge containing food was noted to have food spillage on the door and shelves. The fridge top was covered in old dirt and the floor underneath the fridge, which had been pulled out, was dirty with dried substance stains. (134)

On January 21, 2014, at 11:11, inspector #133 observed in the other medication room, clean nursing supplies were stored in bins and boxes on shelving beneath the medication fridge. The front outer edge of the bins were dirty with dried matter and dust. The lower shelf was dirty with accumulated dust and dried light colored matter. (133)

On Jan 21, 2014, at 11:46, inspector #133 observed that at the end of the hallway, after a specific bedroom, the lower wall covered by pink protective covering was dirty with dried orange/brown colored matter. Along the window area, the lower right window ledge was dirty with dried pink matter and crumbs. The entire lower window ledge and baseboard along this window wall was dirty with crumbs, debris and dried matter. (133) [s. 15. (2) (a)]

2. The licensee has failed to comply with LTCHA, S.O. 2007, c.8, s. 15. (2) (b), in that the licensee has failed to ensure that resident`s personal clothing is delivered back to them after it has been cleaned.

On January 17, 2014, resident #770's closet, the inspector found two clothing items belonging to two other current residents. Within resident #770's dresser drawers, the inspector found clothing items belonging to two former residents. Within resident #770's roommate's dresser drawers, the inspector found two clothing items belonging to resident #770.

On January 17, 2014, in resident #846's dresser drawers, the inspector found four clothing items belonging to their roommate, and one clothing item belonging to

another resident. In resident #846's roommate's dresser drawers and clothing closet, the inspector found four clothing items belonging to resident #846, and three clothing items belonging to one other resident.

On January 17th and 20th, 2014, in six other resident's dresser drawers, the inspector found clothing items belonging to their roommates in four cases, and belonging to another resident, in two cases. Specific identifying information for all examples noted above was provided to the Administrator during the inspection. (133) [s. 15. (2) (b)]

3. The licensee has failed to comply with LTCHA, S.O. 2007, c.8, s. 15. (2) c., in that the home, furnishings and equipment are not all maintained in a safe condition and in a good state of repair, as evidenced by the observations outlined below.

On the morning of January 14, 2014 in an identified tub room was observed and a white particle board cabinet, storing bottles of bubble bath, 2 hairdryers, an incontinence brief and other miscellaneous items were noted to be in disrepair. The two cabinet doors drag on the floor and both were noted to have areas of missing white surface, exposing the inner particle board. In addition, one of the cabinet doors had a broken hinge. Further to this, in the toilet area of the tub room there was a metal shelf, which stores a suction machine on the top shelf. The bottom shelf was noted to be empty but with patches of rust throughout the surface. (148)

On January 17th, 2014, in the early evening,inspector #133 observed that the closet of an identified bedroom was in poor repair. Both sliding doors were off the tracks, and the inspector was unable to access the left hand side of the closet as the doors were jammed. The Food Services Supervisor was informed and she manipulated the doors so both sides of the closet could eventually be accessed.(133)

On January 17, 2014, at 15:17, inspector #133 observed that in an identified bathroom shared by two bedrooms, ceiling tiles above the toilet were stained with dark circular areas, the baseboard for the lower side wall beneath the sink counter was lying on the floor, and the Left and Right lower side walls, beneath the sink, were deeply gouged. (133)

On January 17, 2014, at 11:52, inspector #133 made observations other identified bedroom and washroom, on the top surface of the pipe cover, to the right of the sink, there was an area where the paint has peeled away and the area was rusty. The top of the shared drawer area, within the bedroom, was in a poor state of repair, in that

the particle board surface was not intact, paint had peeled/chipped away from much of the particle board surface, and it was therefore porous and cannot be effectively cleaned and disinfected. The paint had been chipped/peeled away from the lower bathroom door frame, exposing the metal frame beneath. The paint had been scraped away from the outer surface of the radiator heat cover, between the radiator and the entrance to the bathroom. (133)

On January 20, 2014, at 16:16,inspector #133 observed that in an identified Tub Room, the ceiling, between the toilet and the sink, had been extensively patched. The patched areas were cracked, peeling and chipping. The inspector spoke with one of the home's maintenance workers, who indicated that they did not believe that this remediation work had been done recently. (133)

On January 20, 2014, at 16:05,inspector #133 observed that in the washroom of an identified bedroom, the lower bathroom door paint was chipped and gouged. (133)

On January 20, 2014, at 15:45, inspector #133 observed that in the washroom in an identified bedroom, there were 4 stained ceiling tiles, above the toilet. The lower washroom door frame paint had been scraped away, exposing the metal beneath, more pronounced on the left side, and the lower bathroom door paint was chipped and gouged.(133)

On January 21, 2014, at 15:07, inspector #133 observed that on the lower wall, outside of the entrance area to the dining room, near an identified nursing station, there was a section of light beige protective surface missing. This exposed drywall was gouged, scraped and cracked.(133)

On January 21, 2014, at 15:01,inspector #133 observed that on the lower wall in the hallway, between two bedrooms, a corner of a section of the pink protective surface had been broken off. The lowermost area was peeling away from the wall underneath, and it was not flush to the wall, protruding outwards. (133)

On January 21, 2014, at 14:55, inspector #133 observed that in the washroom shared by two identified bedrooms, underneath the lower grab bar, next to the toilet, a patch of paint and drywall had been peeled away, exposing a porous surface beneath, which cannot be effectively cleaned and disinfected.(133)

On January 21, 2014, at 14:30, inspector #133 observed the condition of the ceiling, in

the area of the nursing clerk office, around the corner in front of an identified nursing station, to the entrance of the dining room. The ceiling was stained, cracked and peeling in areas (for example, around the ceiling cameras, around the light fixtures, around access panels). One of the home's maintenance workers explained to the inspector that all of this is as a result of an ongoing problem, primarily related to the saturation of ceiling pipe insulation in the summer when the air conditioning system is running. There was a large area, near the ceiling cameras, which the inspector was told experiences recurring water damage, and which at the time of the inspection had a temporary patch of pressed board over it.(133)

On January 21, 2014, at 11:56, inspector #133 observed the washroom in an identified bedroom and it was noted that ceiling tiles above the toilet were stained a light brown/yellow colour. A hole had been cut beneath the sink, around the pipes, exposing the internal plumbing, and the drywall below this cut area was cracked, stained and dirty with some dried matter. While the sink appeared to be secured to the wall, it rested on an angle, with a pronounced tilt to the right. Along the edge of the lower right corner of the bathroom door, the wood was splintered and some of the outer surface had come away. The splintered wood could catch on clothing.(133)

On January 21, 2014, at 10:32, inspector #133 observed a black padded office chair, with arms rests, that was in poor repair, at an identified nursing station. The front section of the arm rests were worn and damaged. On the left side, the outer surface was cracked, ripped, and no longer attached to the sides or the very front. The foam beneath was exposed. On the right, the outer surface was cracked, ripped and torn, and the foam beneath was exposed. These hand contact surfaces cannot be effectively cleaned and disinfected. The same style of chair, in a very similar state of disrepair, was observed by inspector #133 at the 2 South nurse station, later that morning.(133)

On January 21, 2014, at 10:05, inspector #133 observed an identified medication room. This room is used for medication storage and preparation, storage of resident personal care items, and as a general work space for registered staff. The inspector noted that the sink counter was in a poor state of repair. Beneath the Arborite top surface, the particle board edge, particularly in the immediate area of the sink, was no longer covered by an intact surface and was therefore porous and cannot be effectively cleaned and disinfected. This was also seen on the top and bottom edge of wooden drawers, which are hand contact surfaces given the absence of knobs. In addition, a length of baseboard was missing on the lower wall to the left of the

medication fridge, and along the corner wall. The corner of this wall area was damaged, drywall was missing and the metal corner bracket was exposed. Later that morning, the inspector observed the 2 South medication room and found the sink counter and drawers to be in similar condition to what was observed in the 2 North medication room. As well, the surface of the top shelf of the computer desk was heavily worn, so areas of particle board beneath were exposed. This renders the surface porous, and it cannot be effectively cleaned and disinfected.(133) [s. 15. (2) (c)]

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 with the requirement that the home, furnishings and equipment are kept clean and sanitary, that resident's personal clothing is delivered back to them after it is clean, and that the home, furnishings and equipment is maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to comply with O. Reg 79/10, s.36 in that staff did not use a safe transferring technique when assisting Resident #1.

On a specified date in December 2013, resident # 1 was transferred after supper from the wheel chair to the bed by one Personal Support Worker. This transfer resulted in resident #1 sustaining an injury. It was noted in the most current plan of care and the plan of care in place at the time of the incident, that resident #1 is at high risk for falls and requires a two person transfer. (126)

Discussion held with ADOC on January 21, 2013, indicated that when he completed the investigation, staff member #S101 reported that on the identified date, he/she transferred resident #1 on her/his own. The ADOC reported to inspector #126 that he changed the transfer logo after the December 2013 incident, in resident #1's room, to indicate " two person transfer".(126)

Discussion held with staff member #S101 on January 21, 2013, who indicated to Inspector #126 that a one person transfer was performed on the identified date and that he/she was not aware that resident #1 was a two person transfer. It was noted in the kardex in place at the time of the incident, that, Resident #1 was a two person transfer. (126) [s. 36.]

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 staff use safe transferring techniques when assisting residents,, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident’s substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10 section 34 (1) (a), in that oral care to maintain oral integrity was not provided in morning and evening.

Resident #774 was interviewed January 14, 2014 at 14:00 and reported that generally the evening staff brush their teeth and provide mouth care once a day. Resident #774 indicated that he/she would feel better if their teeth were brushed twice a day.

On January 17, 2014 at 15:30, resident #774 reported that their teeth were brushed that morning by a different nurse from the second floor. The resident reported that morning mouth care was not routinely provided. Resident #774 mentioned that the regular PSW assigned to their care was also assigned to care for the two other residents in the same room and does not have time to brush their teeth in the morning because she has too much to do to prepare everyone for breakfast on time. The plan of care was reviewed and there was an entry under section Dental Status indicating resident #774,has their own teeth and was able to do their oral care when set up by staff. On January 21, 2014 at 10:00, Resident #774 was interviewed and reported that he/she was happy to have had mouth care for two mornings in a row and claimed that this was different than usual. [s. 34. (1) (a)]

WN #5: 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,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 87. (2) d. in that procedures have not been developed and implemented to address incidents of lingering offensive odors in one washroom shared by four residents which is known to be problematic with regards to lingering urine odors, until such time that the flooring is replaced in an effort to resolve the issue.

On January 17th, 2014, at 15:09, the inspector noted a strong lingering urine odor in a washroom shared by four residents in two bedrooms. Resident #739, who resides in one of the bedrooms, informed the inspector that the washroom had been cleaned at 13:30 on that day. Resident #739 indicated that the lingering urine odor goes away after the washroom is cleaned, and returns about an hour or so later. The inspector did not observe any dried urine on the outer toilet or on the floor at the time. Resident #739 informed the inspector that they have been told the floor in the washroom will be replaced in an effort to resolve the lingering urine odor.

On January 20th, 2014, at 12:16, the inspector returned to the identified bathroom and again noted a strong lingering urine odor. The inspector did not see any dried urine on the floor or on the outer toilet at the time.

On January 21st, 2014, at 09:48, the inspector returned to the identified washroom and again noted a strong lingering urine. The inspector noted dried urine on the front of the toilet bowl and on the floor around the base of the toilet.

On January 21, 2014, at 12:22, the inspector spoke with a member of the housekeeping department who was responsible for cleaning the identified washroom, #S122, about the lingering urine odor. They indicated they had not yet cleaned the identified washroom, and that as far as they knew, there were not extra interventions in place to manage the lingering urine odor. Staff member #S122 said that the washroom smells good immediately after it is cleaned, and the smell returns within a short period of time. The inspector noted that the dried urine, observed on the floor at 9:48 that morning, was still on the floor as the housekeeper had not yet cleaned the

bedrooms in the area.

On January 21st, 2014, at 12:45, the inspector spoke with the interim lead for the housekeeping and laundry departments. They indicated that there has been a process of obtaining quotes for the remediation work required for the identified washroom, due to the lingering urine odor. The inspector asked if they knew of any specific interventions in place to manage the lingering urine odor before the remediation work occurs. The interim lead indicated that if nursing staff observe urine or feces on a bathroom or bedroom floor, they are to report immediately to housekeeping staff in order to ensure it is cleaned without delay. The interim lead indicated there was no specific interventions in place for the identified washroom. The Administrator later confirmed to the inspector that remediation work will occur in the identified washroom.

On January 21st, 2014, at 15:35, the inspector noted a strong lingering odor of urine in the identified washroom. There was no dried urine on the floor or in the toilet at the time. Resident #739, who resides in one of the identified bedrooms, reported to the inspector that they felt this bathroom has been problematic with regards to lingering urine odor “for about two years now”, and that it is not unusual for them to find urine on the bathroom floor when they go in to use the toilet. [s. 87. (2) (d)]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S) REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:			
REQUIREMENT/ EXIGENCE	**TYPE OF ACTION/ GENRE DE MESURE**	**INSPECTION # / NO DE L'INSPECTION**	**INSPECTOR ID #/ NO DE L'INSPECTEUR**
O.Reg 79/10 s. 134.	CO #001	2013_230134_0020	134

Issued on this 24th day of January, 2014

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