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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 4, 2019	2019_671684_0014	001660-19	Other

Licensee/Titulaire de permis

Orillia Long Term Care Centre Inc.
c/o Jarlette Health Services 5 Beck Boulevard PENETANGUISHENE ON L9M 1C1

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

Leacock Care Centre
25 Museum Drive ORILLIA ON L3V 7T9

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

SHELLEY MURPHY (684), COREY GREEN (722), RYAN GOODMURPHY (638)

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): March 18-22, 25-26, 2019.

The following intake was inspected during this Other inspection:

-One log related to deferred items from RQI Inspection #2018_657681_0025, specific to the maintenance in the home.

A Follow Up inspection #2019_671684_0012, Critical Incident (CI) inspection # 2019_671684_0011, and Complaint inspection #2019_671684_0013, were conducted concurrently with this inspection.

The Inspectors also conducted daily tours of the resident care areas, observed the provision of care and services to residents, reviewed relevant policies, procedures, programs and resident health care records.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Co-Directors of Care (Co-DOCs), Environmental Services Manager (ESM), Restorative Care Coordinator, Volunteer Coordinator, Culinary Manager, Life Enrichment Coordinator, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeeper, residents and families.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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	Légende 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. 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 ensure that the home, furnishings and equipment were maintained in a good state of repair.

During Resident Quality Inspection (RQI) #2018_657681_0025, that was completed in October 2018, the Inspector observed that the bathroom vanity in resident #004's bathroom was missing a strip of laminate on the right side and wood was exposed.

Inspector #722 made observations of the laminate surface on the vanities in bathrooms located in a number of resident rooms on two specified days in 2019, and made the following observations:
- Room #1: A strip of laminate was missing from a section on the top of the vanity, on the right side, leaving unfinished wood exposed.
- Room #2: Laminate was peeling from from the lower cupboard door of the vanity.
- Room #3: A strip of laminate was peeling from the front surface of the counter top, and a piece of tape had been applied to secure the laminate strip to the vanity. The laminate was also peeling along the right side of the vanity near the wall; and from the lower cupboard door, exposing the fiber board surface below.
- Room #4: Laminate was observed peeling from the front edge of the vanity, under the counter top below the sink.
- Room #5: A section of laminate was missing from the cupboard door and wood was exposed; the laminate surface was also peeling on the sides of the cabinet of the vanity.
- Room #6: Sections of laminate were observed peeling from the cupboard door; as well as a large strip that was hanging off from the front edge of the counter, below the sink.
- Room #7: Laminate was peeling from the left side of the lower cabinet of the vanity.
- Room #8: Sections of laminate were peeling from the corners of the lower cupboard door, as well as the right side panel on the counter near the wall.

- Room #9: Sections of laminate were peeling from the corners of the lower cupboard door.

Inspector #722 interviewed several PSWs related to the damaged vanities in several resident bathrooms: PSW #103 confirmed that the strip of laminate was missing from the right side of the vanity in the bathroom of resident room #1; PSW #104 confirmed that the laminate was peeling from the cupboard door of the vanity in the bathroom of resident room #2, and; PSW #105 confirmed that the laminate surface was peeling from the vanity in the bathroom of resident room #3.

During the interviews with Inspector #722, three PSWs indicated that staff were required to report any damage that required repairs in the maintenance log book in the corresponding resident home area, and that the Environmental Services Manager (ESM) completed the repairs and indicated in the the book when the repairs were completed. All three PSWs were unsure how long the laminate surfaces on the vanities in the specified resident rooms were damaged, and indicated that they had not reported the damage in the maintenance log.

Inspector #722 reviewed the maintenance binder for a specified period of time in 2019, for the resident home area where resident rooms #2, 3, 5, 6, 7, 8, and 9 were located, and there were no entries related to damage to the vanities in the bathrooms of the identified resident rooms. PSW #104 reviewed the same maintenance log for the same period of time with Inspector #722, and verified that there were no entries for damaged bathroom vanities in any resident rooms during this period.

Inspector #722 reviewed the monthly inspection for a specified month in 2019, which was completed by the supervisor from Superior Facility Services. The condition of the laminate surfaces of the vanities in the bathrooms of resident rooms were not identified during the audit.

Inspector #722 interviewed the ESM related to the laminate that was peeling from various vanities in resident rooms. The EMS acknowledged that the laminate was peeling from bathroom vanities located in specific resident rooms. The ESM acknowledged that the identified vanities were damaged and required repair, and that housekeeping staff would have difficulty appropriately cleaning the surfaces where the laminate was peeling away and leaving unfinished wood surfaces exposed.

During the interview with Inspector #722, the ESM indicated that they were aware that

the laminate was peeling from the bathroom vanities in some resident rooms. The ESM indicated that they had spoken with the Administrator about the condition of the vanities in some of the resident bathrooms, and indicated that an outside contractor was hired and had repaired some of the bathroom vanities in resident rooms over the past year. The ESM indicated that there was no plan in place to continue repairing the peeling laminate on the bathroom vanities.

Inspector #722 interviewed the Administrator, who indicated that they were aware that the laminate surface was peeling from some of the vanities in resident bathrooms, but were not aware that the issue was so extensive. The Administrator indicated that a contractor had been hired to do larger repairs in the home, and acknowledged that the contractor had repaired some of the vanities over the past year. The Administrator indicated that the contractor was repairing the surfaces in some of the nursing stations, but there was currently no plan to repair the vanities in resident washrooms. They also stated that they intended to do an audit to identify bathroom vanities that required repairs in resident rooms, and would work to get the damage to the vanities repaired. [s. 15. (2) (c)]

Issued on this 30th day of April, 2019

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

Original report signed by the inspector.