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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 12, 2018	2018_610633_0021	011081-18, 028737-18	Resident Quality Inspection

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

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

The Village of Riverside Glen
60 Woodlawn Road East GUELPH ON N1H 8M8

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

SHERRI COOK (633), BERNADETTE SUSNIK (120), MARIA MCGILL (728), MARIAN MACDONALD (137), SHARON PERRY (155)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 30 and 31, November 1, 2, 5-9, 13 and 14, 2018.

The following intakes were completed during this inspection:

Log # 011081-18- Follow-up to order #001 from inspection 2018_580568_004 and critical incident log #003382-18 related to medication.
Complaint log #007862-17- related to cleanliness of the home.
Critical incident log #006632-18, #006024-18, #002821-18, #004603-18, #013074-18, #009723-18, #007927-18, and #007966-18- related to infection control.
Critical incident log #025223-18, #016569-18, #017583-18, #009698-18 and #004484-17- related to falls prevention.

Inspectors Amanda Owen #738 and Kim Byberg #729 were present during this inspection.

During the course of the inspection, the inspector(s) spoke with the General Manager, the Assistant General Manager (AGM), the Director of Nursing (DON) , the Assistant Director of Care, Assistant Directors of Nursing Care/Personal Expressions Response Team Lead (ADNC), the Recreational Director, the Director of Environmental Services (DES), the Housekeeping Supervisor, the Assistant Food Services Manager, Neighbourhood Coordinators, a Kinesiologist, a Resident Assessment Instrument (RAI) Coordinator, Registered Nurses, Registered Practical Nurses (RPN), Personal Support Workers (PSWs), Personal Care Aides, Food Services Aides, a Administrative Assistant, a Housekeeper, a Laundry Aide, family members and residents.

The inspector(s) also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Additionally, the inspector(s) observed medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports and the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Trust Accounts

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **4 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 114. (3)	CO #001	2018_580568_0004	155

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 O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

The licensee failed to ensure that all doors leading to non-residential areas were locked when they were not being supervised by staff.

The soiled utility room and linen room on three specific dates were unlocked and accessible without using the code entry that was located on the door handle. These rooms were located in the hallway and were accessible to residents. One room contained specific items and chemicals.

Maintenance documentation was submitted and stated the doors were not functioning.

A RPN said that they were aware that there were concerns with the operation of the doors and that maintenance was looking at one or all of the doors. The DES and the AGM said that the linen room and soiled utility rooms were to be kept locked.

The home failed to ensure that all doors leading to non-residential areas were locked when they were not being supervised by staff.

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 doors leading to non-residential areas were locked when they are not being supervised by staff, to be implemented voluntarily.

WN #2: 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,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).
(c) removal and safe disposal of dry and wet garbage; and O. Reg. 79/10, s. 87 (2).
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee failed to ensure that procedures were developed and implemented for cleaning of the home, specifically related to shower chairs, tub lift chairs, tub surfaces and wall surfaces in tub and shower rooms.

All six shower rooms at the home were observed with shower chairs that had heavy amounts of scale on the base and sides. The interior tub surface at the head of the tub in one tub room also had some scale build-up. DES said that housekeepers did not clean the interior of tubs or shower chairs and had not been allocated the task of descaling the chairs or tub surfaces. The ADNC said that the health care aides were to clean the tubs and shower chairs after each use with a disinfectant product. The licensee's policy related to tub and shower chair cleaning directed staff to disinfect the surfaces but there was no instruction included related to descaling the chairs or use of a descaler product to prevent scale build-up.

Two tub lift chairs were observed to have heavy amounts of yellow coloured soap and scale residue on the underside. The amount of residue was an indicator that the undersides of the chair had not been cleaned for a number of days. The licensee's policy related to cleaning of equipment in tub rooms stated that the tub chair brush was to be used to scrub down the chair, including underneath the chair after each use.

Tiled wall surfaces in two shower rooms were observed with visible scale build-up. According to the housekeeping procedures for deep cleaning of tub and shower rooms provided by the DES descaling was not included.

The licensee did not ensure that procedures were developed and implemented for cleaning of the home, specifically related to descaling shower chairs, tub lift chairs, tub surfaces and wall surfaces in tub and shower rooms.

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 as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, that procedures are developed and implemented for cleaning of the home, specifically related to shower chairs, tub lift chairs, tub surfaces and wall surfaces in tub and shower rooms, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and O. Reg. 79/10, s. 90 (1).
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

The licensee failed to ensure that as part of the organized program of maintenance services under clause 15 (1) (c) of the Act, that there were schedules and procedures in place for routine, preventive and remedial maintenance.

Two wooden cabinets were observed to not be maintained in good repair. The top surfaces were eroded, with flaking, cracked and lifting wood veneer.

The licensee's maintenance related policies and procedures did not include any procedures related to maintaining furnishings in the home.

The licensee failed to ensure that as part of the organized program of maintenance services under clause 15 (1) (c) of the Act, that there were schedules and procedures in place for routine, preventive and remedial maintenance related to the furnishings in the home.

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 as part of the organized program of maintenance services under clause 15 (1) (c) of the Act, that there were schedules and procedures in place for routine, preventive and remedial maintenance, to be implemented voluntarily.

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 :

The licensee failed to ensure that all staff participated in the implementation of the infection prevention and control program.

As per subsection 3, the infection prevention and control program was to include cleaning and disinfection practices that are implemented to reduce infection transmission in the home.The ADNC said that cleaning and disinfection practices related to resident care devices such as bed pans and wash basins were reviewed with all PSWs and directions were given.

The licensee's related policy did not include instructions for the cleaning agent to use in the dishwasher. In addition, no direction was included as to how the personal care ware was to be handled after each use.

On two specific dates, no disinfectant wiping cloths were found in any housekeeping closet. Only one out of six soiled utility rooms contained disinfectant wiping cloths.

The licensee failed to ensure that staff were participating in the implementation of the infection prevention and control program related to the cleaning and disinfecting of bed pans and wash basins at the home.

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 are participating in the implementation of the infection prevention and control program related to the cleaning and disinfecting of bed pans and wash basins, to be implemented voluntarily.

WN #5: 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. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

1) A medication incident report showed that an identified resident had been given two times the amount of an ordered medication for a specific period of time. The resident was assessed and there were no ill effects noted from this incident.

2) The home submitted a CIS report related to a medication incident that resulted in a resident being sent to hospital on two separate occasions. The resident had received the wrong dose of a specific medication. The resident required treatment as a result of this incident.

A RPN said that the medication was not administered to the resident as ordered by the physician for one identified resident. The DON said that both residents did not receive their medications as prescribed.

The licensee failed to ensure that drugs were administered to two identified residents in accordance with the directions for use specified by the prescriber.

Issued on this 19th day of December, 2018

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

Original report signed by the inspector.