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 Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 2, 2014	2014_263524_0010	L-000171-14	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

ELMWOOD PLACE
46 ELMWOOD PLACE WEST, LONDON, ON, N6J-1J2

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

INA REYNOLDS (524), DEIRDRE BOYLE (504), RAE MARTIN (515)

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): March 10, 11, 12, 13, 14, 17, 18, 19, 20, 2014.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care, Food Service Manager, Program Manager, Business Manager, Environmental Services Manager, RAI Coordinator, 2 Registered Nurses, 3 Registered Practical Nurses, 13 Personal Support Workers, 1 Activity Aide, 1 Cook, 4 Dietary Aides, 2 Housekeeping Aides, 1 X-ray Technician, 20 Residents and 3 Family Members.

During the course of the inspection, the inspector(s) toured all resident home areas, observed meal service, medication passes, medication storage areas and care provided to residents, resident/staff interactions, infection prevention and control practices, reviewed medical records and plans of care for identified residents, postings of required information, minutes of meetings related to the inspection, reviewed relevant policies and procedures of the home, and observed the general maintenance, cleaning and condition of the home.

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
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
Safe and Secure Home
Skin and Wound Care
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 LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that,
(a) there is an organized program of housekeeping for the home; 2007, c. 8, s. 15 (1).
(b) there is an organized program of laundry services for the home to meet the linen and personal clothing needs of the residents; and 2007, c. 8, s. 15 (1).
(c) there is an organized program of maintenance services for the home. 2007, c. 8, s. 15 (1).

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 there is an organized program of laundry services to meet the linen needs of the residents as evidenced by:

On March 12 and 13, 2014, nine resident rooms were observed and found to not have towels or face cloths available to the Residents. This was confirmed by a Personal Support Worker.

On March 14, 2014, five resident rooms were observed and found to not have towels or face cloths available to the Residents. This was confirmed by the Environmental Services Manager.

On March 14, 2014, through observation it was revealed that there were no clean towels available in the two linen closets or in the two housekeeping carts. This was confirmed by the Environmental Services Manager.

On March 14, 2014, through record review it was revealed that the laundry service procedures do not provide direction for re-supplying clean towels and face cloths to all Residents. The towels and face cloths are delivered to the Resident's bathroom during the night shift. After morning care, the soiled linens are placed in the laundry hamper by staff who provide care to the Residents. The removed face cloths and towels are

not replaced by staff unless a Resident requests to be re-supplied. There is no provision for re-supplying the linens to Residents who are incapable of asking for replacement linens during the day and evening shifts. This was confirmed by the Environmental Services Manager. [s. 15. (1) (b)]

2. The Licensee has failed to ensure the home's furnishings and equipment are kept clean and sanitary as evidenced by:

On March 11, 2014, the following housekeeping concerns were observed:
- heavy dust accumulation was noted on the exhaust vent in an identified Resident bathroom; a buildup of dust/debris was noted under and behind identified Resident beds and around the electric baseboard heater.
- cobwebs and dust accumulation was observed on the exhaust vent in an identified Resident bathroom.
- accumulation of dirt and crumbs observed in the corner of the floor beside the china cabinet.
- baseboards were visibly soiled in a hallway. [s. 15. (2) (a)]

3. On March 10, 11, 12, 2014, numerous Resident rooms and bathrooms were observed to have black scrapes on the walls and to be visibly soiled.
On March 11, 2014, in an identified Resident room, the floor was observed to be soiled and there was visible debris present. This was confirmed by a Personal Support Worker.
On March 11, 2014, in an identified Resident room, the furniture was observed to be visibly soiled and the floor was soiled with visible debris present. This was confirmed by a Personal Support Worker.
On March 11, 2014, in an identified Resident room, the floors were soiled with visible debris present. The furniture was observed to be dusty and the bathroom sink was soiled. This was confirmed by a Personal Support Worker.
On March 12, 2014, in an identified Resident room, the bathroom sink was visibly soiled. The furnishings were visibly soiled with debris present. Furniture was dusty and unclean with a substance present on the bedside table. This was confirmed by a Personal Support Worker.
On March 12, 2014, in an identified Resident room, the furnishings were observed to be visibly soiled with debris present.
On March 20, 2014, the round table in a lounge was observed to be visibly soiled with debris present and to have a sticky substance on the surface. This was confirmed by a Personal Support Worker. [s. 15. (2) (a)]

4. The Licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair as evidenced by:

On March 10,11,12,13,14, 2014, observations of the home areas revealed the following:
-cracked ceiling tiles in the hallway by the printing room and kitchen/laundry area.
-activity room wall had a gouge that was patched but not painted.
-a washroom toilet tank plunger was stuck open and not filling after flushing.
-cracked ceiling tiles noted near an emergency exit.
-a toilet tank lid was missing and had a white plastic tray placed upside down over the tank.
-wall sconce missing over light bulb in a hallway. Drywall patched and not painted in a hallway.
-in a hallway, the baseboard was observed to be attached to the wall with 6 coloured push pins. This was confirmed by the Director of Care.

On March 10, 11, 12, 13, 14, 2014, observations of identified resident rooms revealed the following:
-exhaust fan in a bathroom was hanging loose and visibly soiled and partially obstructed with dust, chipped wallboard in the bathroom, cracked and stained ceiling tile and a broken baseboard heater.
-sink in bathroom corroded at the drain inside the sink, 2 exposed rusted bolts visible on toilet and cap covers were missing.
-bathroom electric baseboard heater not secured to the wall, bolt cap cover missing on toilet, stained ceiling tile in the bathroom, corrosion in toilet bowl and a corroded electric baseboard heater in the bedroom.
-door handle to a bathroom loose.
-window jammed opened in the metal track in an identified resident room.
-footboard unattached to a bedframe.
-a broken towel rack hanging from another towel rack in a bathroom.
-a bedside table door did not close.
-an overbed table was cracked down the middle with the two halves of the table top separating and unstable.
-an overbed table was observed to be soiled and in disrepair with a piece of the steel frame sticking out from the table top. The overbed table was dented, paint was excessively chipped from the table stand.
-a patch of drywall in a bathroom, approximately 12x8cm was unpainted next to the

sink. This was confirmed by the Executive Director.
-Numerous baseboards were observed in Residents rooms detaching from the walls.
-Numerous door frames leading to Residents rooms and bathrooms were chipped and scraped and in need of paint.
-Numerous walls in Residents rooms and bathrooms were observed to be scraped, chipped, soiled and in need of paint.
-Numerous dry wall patches unpainted.

Interview with the Environmental Manager and Executive Director confirmed the need for repairs and that repairs have been initiated. [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 to ensure there is an organized program of laundry service to meet the linen needs of residents, that the home, furnishings and equipment are kept clean and sanitary, and 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. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times as evidenced by:

On March 10, 11 and 12, 2014, 8 bathroom call systems were identified where Residents were unable to activate the call system. The call system cord in identified resident bathrooms were secured to the grab bar beside the toilet. This prevented the Resident from activating the call system. Two call systems in identified bathrooms separated at the green connector when pulled and did not activate the call system. This was confirmed by the Executive Director and the Environmental Manager. [s. 17. (1) (a)]

2. On March 11 and 12, 2014, the call bell for Resident #753 was observed on the floor next to the bed and out of reach. This was confirmed by a Registered Nurse and a Personal Support Worker.
Through record review it was revealed that the Resident is at high risk for falling. The Resident's care plan for fall prevention states: "Ensure call bell within reach. Reinforce need to call for assistance."

On March 12, 2014, the call bell for Resident #784 was observed on the floor next to the bed and out of reach. This was confirmed by a Personal Support Worker. [s. 17. (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 the home is equipped with a resident-staff communication and response system that can be easily seen, accessed and used by residents, staff and visitors at all times, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(c) a cleaning schedule for the food production, servery and dishwashing areas. O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. The Licensee has failed to ensure that the home has a cleaning schedule for the servery areas as evidenced by:

During the inspection, the following was observed in the servery area:
- the cupboards and drawers were visibly soiled with dried food and liquid debris.
- the floor space between the counter and refrigerator had a buildup of debris.
- the refrigerator had spills in it and the door handle and surface areas were stained and/or had a build up of debris.
- the garbage cans were covered with stains and liquid spills.
- there was a buildup of debris under the steamtable and on the floor mat.
- the feeding stools, chair frames and table legs were visibly soiled with dried food and liquid debris.

Interview with the Food Service Manager on March 18, 2014 confirmed that there was no cleaning schedule for the servery areas. The Food Service Manager stated that the expectation is that staff clean the servery areas at the end of each shift. [s. 72. (7) (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 to ensure that the home has a cleaning schedule for the servery areas, to be implemented voluntarily.

WN #4: 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,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The Licensee has failed to ensure that as part of the organized program of maintenance services there are schedules and procedures in place for routine, preventive and remedial maintenance as evidenced by:

A review of the maintenance records revealed that there is no documented evidence there are schedules and procedures in place to correct the deficiencies identified throughout the inspection.

A review of the Preventative Maintenance Summaries Reports for January, February and March, 2014, revealed that there was incomplete documentation as well as no documentation on the Preventative Maintenance Painting/Repair sheet for the same time period.

On March 17, 2014, the Executive Director confirmed that a monthly Preventative Maintenance Summaries report is not submitted and the Preventative Maintenance Painting/Repair sheets were incomplete. The Executive Director further shared the expectation is that the report be submitted monthly, reports are to be complete and schedules and procedures should be in place for routine preventative and remedial maintenance. [s. 90. (1) (b)]

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 there are schedules and procedures in place for routine, preventive and remedial maintenance, to be implemented voluntarily.

WN #5: 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. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The Licensee has failed to ensure that the infection prevention and control program is evaluated and updated at least annually as evidenced by:

A review of the annual Infection, Prevention and Control Program evaluation for 2013 dated March 2014, revealed that no data was documented for the first three quarters of the year.
On March 19, 2014, the Director of Care confirmed that the program evaluation was not done. [s. 229. (2) (d)]

2. The Licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program as evidenced by:

On March 10, 2014, 7 infection control carts with equipment were observed to be visibly soiled. There were signs on the carts stating "Please ensure units are clean and stocked with enough supplies for 24 hours".

On March 10, 2014, a used unlabeled comb was found in a shared bathroom. A Personal Support Worker confirmed that this comb should not be there and is now unusable.

On March 10, 2014, a used nail file was found in a shared bathroom. A Personal Support Worker confirmed that this nail file should not be there and it was removed.

On March 11, 2014, a record review revealed Resident #742 had a diagnosis documented in the medical record which required specific interventions. The resident's plan of care directs staff to follow the specific interventions. There were no directions in place related to these interventions. A Personal Support Worker confirmed that directions should be posted regarding these interventions for staff. [s. 229. (4)]

3. The Licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program as evidenced by:

On March 10, 2014, through observation of Resident #747 it was revealed that the Resident's walker was soiled. The seat had debris present, several stains and a crusty brown substance on it. The handles of the walker were visibly soiled and a sticky substance was noted on one handle. The frame of the walker was visibly soiled with white and brown substances. This was confirmed by a Personal Support Worker.
On March 11, 12, 13, 14, 17, 18 and 19, 2014 during lunch service, numerous walkers that were parked outside of the dining room were noted to be visibly soiled, stained and malodorous with debris present.
On March 19, 2014 during lunch service, through observation of 11 walkers and 6 wheelchairs it was revealed that those mobility aides were visibly soiled. This was confirmed by the Director of Care.

Through interview with the Director of Care it was revealed that the Home's expectation is that the Residents' wheelchairs, walkers and canes would be cleaned according to the Home's infection control policy which sets out direction to staff to clean the Residents' mobility aids twice per week on the Residents bath days. The Director of Care confirmed that the policy was not followed.

On March 10, 2014, a visibly soiled unlabeled kidney basin containing a visibly soiled unlabeled toothbrush and a visibly soiled unlabeled glass were observed in a shared bathroom. This was confirmed by a Personal Support Worker.

On March 10, 2014, a soiled unlabeled comb and an unlabeled bottle of body wash were observed in a shared bathroom. This was confirmed by a Personal Support Worker.

On March 11, 2014, a wash basin was found on the floor beside the toilet in a shared bathroom. This was confirmed by a Personal Support Worker.

On March 11, 2014, the door handle to a room and the door handle to a bathroom were observed to be covered in faeces. This was confirmed by a Personal Support Worker.

On March 12, 2014, faeces was observed on the inside of the sink in a resident bathroom. The face cloth in the Resident's bathroom was visibly soiled with faeces and was hanging on the Resident's towel bar. The Resident relies on staff for care. This was confirmed by a Personal Support Worker.

On March 12, 2014, through observation it was revealed that fingernails of Resident #141 had faeces present. The Resident was observed touching the hand rail along the hallway for approximately 90 metres. This was confirmed by a Personal Support Worker.

On March 18, 2014, a bed pan was observed on the floor of a shared bathroom. This was confirmed by a Personal Support Worker. [s. 229. (4)]

4. The Licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program as evidenced by:

On March 10, 2014, the following observations were made:
-Resident puzzles were lying on a soiled table in the TV room, two used water cups were noted on top of the water cooler, a partially filled glass with juice on counter top at nurses station, staff stock cart had a visibly soiled personal care box on top shelf containing shaving cream, razors and other toiletries.

March 11, 2014, the call bell for Resident #841 was wrapped around the bed siderail with the call button lying on the floor. A Personal Support Worker confirmed the call bell should not be on the floor and picked it up and placed it on the bed without disinfecting the call bell.

March 13, 2014, the hand sanitizer pump outside a resident room did not work. A Personal Support Worker confirmed the pump was not dispensing sanitizer and replaced the bottle. There were signs posted, one for visitors to please wash hands

before and after visiting.

On March 14, 2014, the following observations were made:
Four soiled infection control carts. One of the carts had a soiled patient slider device in the top drawer. Another contained scrap cardboard and an instruction booklet for equipment.

No signage was noted on any of the infection control carts to identify the required contents, and every cart had different quantities and types of equipment.
In an interview with the Executive Director and the Infection Control Lead it was confirmed that the infection control carts should be clean and organized with signage on the cart to identify contents. [s. 229. (4)]

5. The Licensee has failed to ensure each resident admitted to the home is screened for tuberculosis within 14 days of admission, unless the resident has already been screened at some time in the 90 days prior to admission as evidenced by:

A review of the immunization records revealed that there was no documentation of a tuberculosis test completed after admission or within 90 days prior to admission to the home for six randomly selected Residents.

On March 20, 2014, the Director of Care confirmed that TB testing was not completed within 14 days of admission or within 90 days prior to admission for the identified Residents. [s. 229. (10) 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 the infection prevention and control program is evaluated and updated at least annually, that all staff participate in the implementation of the infection prevention and control program, and that immunization and screening measures are in place, to be implemented voluntarily.

WN #6: 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:
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right to live in a safe environment as evidenced by:

On March 11, 2014, a resident room was observed to have low lighting levels in the entry way as the light bulb had burned out. The Resident complained that the closet and the drawers were "in darkness" and had been for "a long time...weeks." The area inside the Resident's room where the closet and drawers are located was observed to be in very low light. This was confirmed by the Administrator.

The Resident's bathroom was observed to be dark. The light switch in the shared bathroom was on the far wall, approximately 6 feet from the entry way. No light was observed. The Resident expressed that it was difficult to "walk in the total darkness over to the light switch." The low light levels in the Resident's bathroom was confirm by the Administrator. [s. 3. (1) 5.]

2. Footrests were found lying on the seat of a wheelchair in a hallway on March 10, 2014, and on the floor in a Resident room on March 12, 2014.

The Executive Director confirmed the footrests are improperly stored to ensure safety and removed them. [s. 3. (1) 5.]

WN #7: 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 the resident as specified in the plan as evidenced by:

On March 11, 2014, observed Resident #832 being wheeled in to the bedroom and placed at the end of the bed facing the window. The call bell was wrapped around the side rail of the bed and out of reach of the Resident. Staff did not reposition the call bell to be within reach before they left the room.

On March 17, 2014, observed the Resident sitting in a wheelchair at the end of the bed. The call bell was clipped to the bedding on the bed and out of reach of the Resident. A Personal Support Worker confirmed the Resident should have a call bell within reach and then attached it to the Resident's clothing.

An intervention identified in the care plan for Resident safety is to ensure the call bell is within reach.

On March 17, 2014, the Director of Care confirmed that staff should be following the care plan. [s. 6. (7)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The Licensee has failed to ensure that each resident who is incontinent receives an assessment as evidenced by:

Through review of the Resident's health record and interview with a Registered Practical Nurse it was revealed that Resident #799 who is incontinent has never had a continence assessment as set out in the Home's Continence Care policy. This was confirmed by the Director of Care. [s. 51. (2) (a)]

Issued on this 5th day of May, 2014

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

Ina Reynolds #524