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

Division de la responsabilisation et de la performance du système de santé
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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
Jun 29, 2015	2015_271532_0018	010407-15	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 WINSTON PARK
695 BLOCK LINE ROAD KITCHENER ON N2E 3K1

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

NUZHAT UDDIN (532), DEBORA SAVILLE (192), JUNE OSBORN (105)

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): June 9, 10, 11, 12, 15 and 16, 2015

During the course of the inspection, the inspector(s) spoke with the General Manager, Director of Nursing Care, Quality Improvement Manager, Resident Assessment Instrument (RAI) Coordinator, Director of Recreation, Director of Environmental Services, Director of Food Services, Registered Nurses, Registered Practical Nurses, Personal Support Workers , Ward Clerk, Activity Aide, Dietary Aide and Housekeeping staff, Residents and Family members.
The inspectors also toured the resident home areas, reviewed clinical records, observed the provision of care and interaction between staff and residents, reviewed relevant policies and procedures, reviewed educational records, general maintenance of the home, and resident communication system, medication storage areas, and reviewed medication records as well as meeting minutes pertaining to the inspection.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **12 WN(s)**
- **4 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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with.

A) The home's policy titled Food Temperature Control indicated that Food Services Team members are to be aware of the danger zone: 4 degrees Celsius to 60 degrees Celsius (40F - 140F) and prepared foods should not be stored, held, or served at "danger zone" temperatures. The policy stated that food temperature checks must be conducted daily prior to food leaving the kitchen, at point of service and at end of service. Foods items to be assessed include proteins, salads, dairy based foods and modified diets including pureed and minced.

Interview with the Director of Food Services confirmed that all temperatures should be taken at point of service for all food items including texture modified diets.

Interview with the Chef indicated that food temperatures had been taken and everything was confirmed to be at an appropriate temperature.

Review of the food temperature record identified that the food temperatures had been taken for the regular textured food items only.

Interview with the a staff member serving the meal confirmed that the temperatures were not taken or recorded for the modified textured diets.

The licensee failed to ensure that the Food Temperature Control policy was complied with on a specified date when food temperatures were not taken and recorded on all food items at point of service.

B) The home's policy titled A.M./H.S. Care indicated that male residents would be shaved with morning care and female residents would be shaved on bath days.

The home's policy titled Spa (Shower, Tub Bath, and Sponge Bath) dated February 2014, indicated that as part of the bathing process, male residents would be shaved and female residents would have facial hair shaved or plucked as per their personal preference.

An identified Resident was observed to have facial hair.

Record review confirmed by interview with the staff member completing the bath identified that the Resident was bathed, however, the staff member confirmed that the Resident did not have facial hair shaved during or following the bath and stated that shaving of the Resident should be completed daily with the morning care.

The identified Resident was again observed on two different identified times with a Personal Support Worker. It was confirmed that the Resident continued to have long facial hair.

The licensee failed to comply with their policy titled Spa (Shower, Tub Bath, Sponge Bath) when the identified Resident did not receive attention to facial hair. [s. 8. (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 the plan, policy, protocol, procedure, strategy or system, is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.
TABLE
Homes to which the 2009 design manual applies
Location - Lux
Enclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 322.92 lux continuous consistent lighting throughout
In all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 lux
All other homes
Location - Lux
Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughout
All corridors - Minimum levels of 215.28 lux continuous consistent lighting throughout
In all other areas of the home - Minimum levels of 215.28 lux
Each drug cabinet - Minimum levels of 1,076.39 lux
At the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 lux
O. Reg. 79/10, s. 18, Table; O. Reg. 363/11, s. 4

Findings/Faits saillants :

1. The licensee has failed to ensure that lighting requirements set out in the lighting table for homes built prior to 2009 were maintained.

All corridors - minimum lux 215.28 continuous consistent lighting throughout.

A) Lux readings using an Ambrobe LM-120 meter were taken for the main corridor on an identified home area. Measurements were taken while walking down the center of the corridor with the light meter approximately 30 inches from the floor. It was cloudy at the time and the readings were taken and in spite of available day light, readings remained below the required 215.28 lux. Readings were taken starting at the far end of the corridor

and working toward the entrance to the home area.

Flush mount florescent lights were noted to be positioned approximately twelve feet apart with wall sconce lighting starting approximately sixteen feet from the end of the corridor and every twenty-two to twenty-four feet. At the center of the corridor by the spa room, the corridor widens and lighting was provided by recessed lighting with no ceiling light and no natural day light.

Light meter readings taken were confirmed with the Director of Environmental Services as follows:

Starting at the far end of the corridor where day light was evident from a window. Taken directly under the florescent light, readings of 202 lux were obtained and were observed to drop to 110 lux between light sources and were 168 lux at the first set of sconces.

Light meter readings taken along the center of the corridor were noted to be less than 215.28 lux except directly under some florescent lights. Readings ranged from a low of 56 lux to a high of 490 lux directly under the florescent light source outside an identified room.

Light meter readings taken directly under florescent light sources outside of identified rooms were noted to be below the required 215.28 lux with daylight coming from the doorways to each room.

Light meter readings taken at the centre of the corridor which opened to provide an area for two lounge chairs and a fish tank and where access to the spa room was located was dependent on recessed ceiling lighting and were between 56 lux and 80 lux.

Light meter readings taken outside the medication room were 163 lux.

The licensee failed to ensure that a minimum illumination level of 215.28 was continuously maintained throughout the corridor on Eby home area even with natural light exposure. [s. 18.]

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 lighting requirements set out in the lighting table for homes built prior to 2009 are maintained, specifically that all corridors have a minimum lux 215.28 continuous consistent lighting throughout, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).**

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).**

**s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).**

**s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).**

Findings/Faits saillants :

1. The licensee has failed to ensure that meals were served course by course unless otherwise indicated by the resident or the resident's assessed needs.

A) During a meal observation in the identified dining room, it was noted that course by course service was not offered for all residents. Identified Residents were observed to be receiving assistance to eat their soup when the main course was served and were continuing to receive assistance with the main course when the dessert was offered and served.

In the identified Dining Room observations confirmed that the resident's were not being served course by course. An identified Resident was observed to have been served soup and later, the same Resident was offered and received the main course, without having taken the soup away. The identified Resident received assistance with the meal and dessert was offered and placed in front of the resident.

Interview with the Director of Food Services and the Director of Nursing Care confirmed that meal service should be completed course by course with dishes from the previous course being removed from the table before the next course was served. [s. 73. (1) 8.]

2. The licensee has failed to ensure that appropriate furnishings and equipment in resident dining areas, included comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents.

A) During a meal observation in an identified dining room two identified residents were observed to be sitting with their chairs positioned parallel to the table. The residents were observed to be fed by staff while positioned facing away from the table. An identified resident was also observed to be sitting parallel to the dining table while being fed their lunch meal.

Interview with the Director of Food Services confirmed that residents should be positioned at the table rather than beside it, but indicated space was a concern in this dining room and resident chairs were getting bigger. Interview also confirmed that the home does not have tables that allow for height adjustment to meet the needs of the residents in the dining room.

The licensee failed to ensure that dining room tables were at an appropriate height to meet the needs of all residents. [s. 73. (1) 11.]

3. The licensee has failed to ensure no person simultaneously assists more than two residents, who need total assistance with eating or drinking.

A) During a meal observation, it was noted that a Personal Support Worker (PSW) was using their feeding stool to wheel between two tables with multiple residents requiring feeding. The PSW was feeding two residents requiring full feeding assistance and encouraging a third resident at the same table. The PSW then started to assist residents at a different table, one requiring cueing and one requiring feeding, while continuing to feed the two residents at the identified table.

During a meal service observation, it was noted that a Personal Support Worker (PSW) was assisting three residents, each requiring feeding assistance for all or part of the meal. The PSW was moving between the three residents on the feeding stool.

During a meal observation in the identified dining room it was also noted that a PSW was providing assistance to two residents requiring full feeding assistance and was assisting one resident at another table who required feeding assistance for the majority of the meal.

The licensee failed to ensure that staff simultaneously assisted no more than two residents who needed total assistance with eating or drinking. [s. 73. (2) (a)]

4. The licensee has failed to ensure that no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

A) During a meal observation on an identified home area, an identified Resident was observed with a bowl of soup sitting on the table in front of them. The resident had their eyes closed and was not participating in the meal. A staff member was intermittently assisting another resident at the same table.

It was observed that forty minutes after the identified Resident was first served soup and twelve minutes after the resident was served the main course, assistance was provided. A staff member fed the resident their entire meal.

During a meal observation it was also observed that fluids were served and sitting on tables for five residents before residents were in attendance in the dining room.

A Personal Support Worker(PSW) was observed placing fluids that had been sitting on a table for forty-five minutes, onto a tray to serve to the resident who had not come to the dining room. After the inspector spoke up to question the PSW, fresh fluids were placed on the tray.

On an identified date soup was served to two residents, who require total assistance to eat, before a staff member was available to assist them with their meal.

The licensee failed to ensure that no resident who required assistance with eating or drinking was served a meal until someone was available to provided the assistance required. [s. 73. (2) (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 meals are served course by course unless otherwise indicated by the resident or the resident's assessed needs; to ensure that appropriate furnishings and equipment in resident dining areas, included comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents; to ensure no person simultaneously assists more than two residents, who need total assistance with eating or drinking and to ensure that no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident, 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 :

1. The licensee has failed to ensure that staff participate in the implementation of the

infection prevention and control program.

A) During a meal observation on an identified date, a staff member serving the meal was observed to clear dirty dishes from tables in the dining room and immediately return to serving meals, without completing hand hygiene, on multiple occasions.

During another meal observation on an identified date, the staff member serving the meal was observed to be clearing tables of dirty dishes, handled by other residents and staff and then returned to serving food to residents without completing hand hygiene.

On an identified date a staff member was observed to have gloved hands. A staff member handled the temperature binder, and touched other hard surfaces including the refrigerator door, then returned to serving the meal without removing and replacing the gloves or completing hand hygiene.

Personal Support Workers were observed to touch hard surfaces such as feeding stools and resident wheelchairs and then return to feeding residents without completing hand hygiene. Staff were also observed to go between multiple residents at different tables assisting to feed the residents, without completing hand hygiene.

Interview with the Director of Food Services confirmed that it would be the expectation of staff of the home to complete hand hygiene using hand sanitizer, or washing hands if heavily soiled after handling dirty dishes and before returning to meal service.

Interview with the Director of Nursing Care confirmed that it would be the expectation of staff of the home that hand hygiene is completed on entering the dining room, after touching hard surfaces and between assisting residents.

The home's policy titled Hand Hygiene indicated that staff are to clean hands between handling clean and dirty dishes, before and during preparation and service of food.

The home's policy titled Personal Hygiene indicated that staff are to wash hands as frequently during the working period as is necessitated by handling objects or touching surfaces which could contaminate food.

The licensee failed to ensure that staff participated in the implementation of the infection prevention and control program. [s. 229. (4)]

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 participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #5: 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident had their right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, respected.

A) During a meal observation, it was observed that while assisting the residents staff were chatting between themselves, chatting with staff and visitors standing at the open window next to the table and were heard discussing the needs of other residents. The residents being assisted were not included in the conversation and conversation was not directed to the identified residents.

During a meal observation, one staff member was observed discussing other resident needs with staff at the window.

Interview with the Director of Nursing Care confirmed that the staff should have focused their attention on the resident that was being assisted and that information about other residents should not be discussed in the dining room.

The licensee failed to ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognized their individuality and respected their dignity was promoted. [s. 3. (1) 1.]

WN #6: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

A) Plan of care and the skin assessment revealed that an identified Resident had an altered skin integrity.

The Resident Assessment Instrument (RAI) Coordinator confirmed that the Resident Assessment Protocol (RAP) summary indicated that the identified resident had an altered skin integrity.

In an interview the Director of Nursing Care (DNC) confirmed that the resident did not have an altered integrity and that the registered staff were only monitoring the skin.

The plan of care plan was reviewed with both the DNC and the Quality Improvement Coordinator and they both confirmed that the plan of care for the altered integrity was not reviewed and revised when the resident's care needs had changed and the care set out in the plan was no longer necessary. [s. 6. (10) (b)]

WN #7: 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 resident-staff communication and response system can be easily seen, accessed and used by residents, staff and visitors at all times.

A) It was noted that a communication and response system in an identified room could not be activated by the inspector. The malfunctioning call bell was reported to the Director of Environmental Services (DES) and repairs were completed. When checked at 1440 hours the communication and response system could be activated.

Interview with the DES confirmed that an annual preventive maintenance program was in place related to call bells in the home. Record review and interview confirmed that communication and response system had not been audited for 2015, as of June 15, 2015.

The licensee failed to ensure that the resident-staff communication and response system could be easily used by residents, staff and visitors at all times. [s. 17. (1) (a)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the Dietary Services and Hydration program are evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

A) Interview with the General Manager and the Director of Food Services confirmed that the dietary services and hydration programs in the home had not been evaluated and updated annually and a record kept of the evaluation as required under regulation 30(1)4. [s. 30. (1) 3.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

A) The General Manager and the Director of Nursing Care confirmed that there has not been an annual review of the Staffing Plan completed. [s. 31. (3)]

WN #10: 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. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident received fingernail care, including the cutting of fingernails.

A) An identified Resident was observed to have long, dirty finger nails.

Record review and interview with the Personal Support Worker(PSW) indicated that the identified Resident had their finger nails cleaned during bathing. The PSW confirmed that the finger nails were not trimmed and was unable to explain how all of the resident's finger nails would become soiled between a specified time frame.

Review of the plan of care under Activities of Daily Living (ADL's) - Bathing indicated that finger nails were to be cleaned and trimmed during bathing.

The home's policy titled Spa (Shower, Tub Bath, Sponge Bath) dated February 2014 indicated that after completing the bath, nail care to feet and hands was to be completed.

The licensee failed to ensure that the identified resident received fingernail care include the cutting of fingernails. [s. 35. (2)]

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee has failed to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results.

A) A member of the Residents' Council shared that the home had not sought advice in developing and carrying out the satisfaction survey and acting on the results.

Residents' Council meeting minutes were reviewed and no documentation was noted to indicate that the satisfaction survey was reviewed with the Residents' Council.

The Director of Recreation confirmed that the home did not seek the advice of the Residents' Council in developing and carrying out the satisfaction survey, and in acting on its results. [s. 85. (3)]

2. The licensee failed to document and makes available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey.

A) A member of the Residents' Council shared that the home had not made available to the Residents' Council the results of the satisfaction survey or sought advice about the survey.

Residents' Council meeting minutes were reviewed and there was no documentation that indicated that the results of the satisfaction survey were made available to the Residents' council.

The Director of Recreation confirmed that the home failed to document and make available to the Residents' Council the results of the satisfaction survey in order to seek the advice of the Council about the survey. [s. 85. (4) (a)]

WN #12: 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,
(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).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented in accordance with manufacturer's specifications, using at a minimum a low level disinfectant in accordance with evidence-based practices and, if there are none, with prevailing practices, for cleaning and disinfection of supplies and devices, including personal assistance services devices, assistive aids and positioning aids.

A) The walker labeled as belonging to an identified Resident was observed to be soiled on the seat area with a dried white substance. The groove and edge all around the seat was full of dried crumb-like debris .

A Personal Care Worker verified the walker as being soiled, the walker was taken to be cleaned immediately.

The Neighbourhood Coordinator confirmed the staff have a cleaning schedule and this walker should have been cleaned according to this schedule, however, it was not. [s. 87. (2) (b)]

Issued on this 29th day of June, 2015

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

Original report signed by the inspector.