



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 le Loi de 2007 les foyers de soins de longue

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

London Service Area Office
291 King Street, 4th Floor
LONDON, ON, N6B-1R8
Telephone: (519) 675-7680
Facsimile: (519) 675-7685

Bureau régional de services de London
291, rue King, 4ième étage
LONDON, ON, N6B-1R8
Téléphone: (519) 675-7680
Télécopieur: (519) 675-7685

Public Copy/Copie du public

Table with 3 columns: Date(s) of inspection, Inspection No, Type of Inspection. Row 1: Nov 22, 28, Dec 17, 19, 2012; 2012_206115_0006; Other

Licensee/Titulaire de permis

LEAMINGTON UNITED MENNONITE HOME & APARTMENTS
22 Garrison Avenue, LEAMINGTON, ON, N8H-2P2

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

LEAMINGTON MENNONITE HOME LONG TERM CARE RESIDENCE
35 PICKWICK DRIVE, LEAMINGTON, ON, N8H-4X5

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

TERRI DALY (115)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the President of Resident Council, the Recreation Manager, three Registered Nurses, three Personal Support Workers, one dietary aide and several residents.

During the course of the inspection, the inspector(s) conducted a tour of the home, observed dining room service on 2 floors, reviewed Resident Council meeting minutes, and 2012 Critical Incidents related to Log# L-001791-12.

The following Inspection Protocols were used during this inspection:

Critical Incident Response

Dining Observation

Infection Prevention and Control

Residents' Council

Findings of Non-Compliance were found during this inspection.



Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 229. Infection prevention and control program
Specifically failed to comply with the following subsections:

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. Concerns identified related to staff participation in the implementation of the infection prevention and control program include:
During a tour of the home items were found to be stored inappropriately.

Staff confirmed that the items were stored inappropriately and provided information on proper storage and infection control practices.

During the meal service, a staff member was observed utilizing the soiled linen/laundry cart, to transport and document the resident's intake in the food and fluid binder.

Issued on this 19th day of December, 2012

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