Ontario

Ministry of Health and Long-Term Care

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

Ministére 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

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
May 22, 23, 24, 25, Jun 4, 12, 13, 19, 20, 21, 26, 27, 28, 2012	2012_093145_0021	Other

Licensee/Titulaire de permis

RITZ LUTHERAN VILLA
R.R. 5, MITCHELL, ON, N0K-1N0

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

RITZ LUTHERAN VILLA
PART LOT 16, CON 2, LOGAN TWN, R.R. #5, MITCHELL, ON, N0K-1N0

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

KARIN MUSSART (145)

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 Environmental Services Supervisor; Director of Care; Acting CEO; 3 Health Care Aides; and 5 residents.

During the course of the inspection, the inspector(s) Conducted other inspection L-000769-12. This inspection was done concurrently with an RQI inspection 2012-087128-0010, Log # L-000691-12; toured all resident and common areas of the home;reviewed policy and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Findings of Non-Compliance were found during this inspection.

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.) 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 subsections:

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;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(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. 1st floor Dining Room:
-Found 9 dining room chair seats stained.
-servery floor, dirt and debris on floor around equipment.
-dirt/debris underneath the hand sink.

2. 1st Floor South Lounge:
-carpet in lounge appeared dirty.

3. Main Kitchen: May 24, 2012
-noted food debris on floor by ice machine. Found one dish under storage rack.

4. A resident wheelchair was found to be dirty with noticeable debris. Resident confirmed that the wheelchair was not being cleaned very frequently.

5. A resident wheelchair seat cushion and belt was found to be very dirty.

6. Resident wheelchair outside of the 2nd floor nurses station had a seat belt that was dirty from food debris.

7. 2nd. Floor East Lounge: 2 brown chairs, stained on seating area.
- 3 green chairs stained on seating area.
- Maximove and Sara 3000 lifts stored in the lounge were dirty
- Wheelchair also stored in lounge has dirty seating area and foot rests.

8. 2nd. Floor North Spa: noted vent fan cover was dirty.

9. 2nd. floor Dining Room: 12/12 dining tables had worn wooden surfaces that were sticky to the touch.

10. In a resident washroom, fan vent cover was covered in dust.

11. 2nd. Floor Hallways: Noted numerous stains on the carpets throughout the entire carpeted area of 2nd. floor. Also, the carpet in the Nurses stations on both 1st and 2nd. Floor.

12. 2nd. Floor Dining Room: May 24, 2012
- where metal transition strips have lifted, there was food debris underneath.
- grooves in the metal transition strips were found to have had dirt/debris in between them.
- counted 11 dining room chairs that were stained on the seating area.
- windows were dirty or covered in cobwebs.
- in the servery, the floor had a buildup of dirt/debris by the hand sink.
- dirt/debris was on the floor underneath the counter overhang and around equipment in the servery.
- dried juice was found on the lower interior surface of the refrigerator.

13. In a resident room:
- a comfortable chair was stained on the seating surface.
- noted urine odor in room.
- toilet bowl had rust stains on inside surface.

14. In a resident washroom, the fan vent cover was dusty.

[LTCHA, 2007, S.O. 2007, c.8, s.15.(2)(a)]

1. Second Floor: May 24, 2012 @ 10:25 am.
- walls scuffed by the elevator.

-walls across from Infection Control Practitioners office damaged.

2. 2nd. Floor Dining Room: May 24, 2012, wall surfaces scraped/damaged throughout the dining room. Wall corners damaged, and piece missing from corner wall protection. Baseboard was pushed in at the corner across from the servery.

3. In a resident room, May 24, 2012 @10:35 am
- room and washroom doors and door frames chipped.
-washroom grab bar stained.

4. In a resident room, May 24 ,2012 @ 10:30 am
-wall by bed rail damaged.
-comfortable chair legs and arms worn.
-washroom door and door frame badly chipped/damaged.
-chunk missing from washroom door.
-room door scraped/damaged.
-damaged walls in the washroom.
-booster seat on toilet, armrest covers were split.
-old toilet paper holder was found to be dirty and rusted.
-washroom walls paint chipped,with old wall plugs left in.

5. Interior of Elevator: Paint chipped on doors, and wall surfaces are scraped.

6. Basement: Resident access corridor: Doors and door frames chipped for hair salon, and other rooms.

7. 2nd. Floor North Spa Room: noted musty odour coming from the shower drain.
- door was paint chipped.
- wall corner at the entrance to the spa was damaged.
- washroom area had holes in the wall.
- baseboard pulling away from the wall beside toilet and beside shower.
- cinder block paint was chipped.

8. 2nd Fl. North Lounge: Blinds broken.

9. 2nd. Floor, East Wing Spa, cupboard door is delaminating with bare wood showing.
- doors were paint chipped.

10. Hole in the wall in hallway on 2nd. floor, May 24, 2012.

11. 2nd. Floor, all wings (North, East, and West) hallway walls, paint was scraped or chipped and damaged.

12. 2nd. Floor East Lounge: May 24, 2012
- 5 chairs and 1 table had damaged legs.

13. 1st and 2nd Floor Nurses Station: counters were chipped and dirty. Door and outside walls were scraped/damaged.

14. Attended a resident room on May 23, 2012 @ 2:49 pm.
- Cupboard doors badly paint scraped.
- room walls badly chipped.
- room door had paint scraped and damage to surface.
- washroom door and door frame had paint chipped.
- grab bar behind the toilet had stains on surface.

- flooring in the washroom was stained.
- wall behind headboard damaged--holes were noted in the wall.
- wall alongside the bedrail damaged---holes were noted in the wall.
- wall behind the headboard damaged. Wall scraped near bedrail.

15. 1st Floor Dirty Utility Room: May 23, 2012 @ 3:00 pm, noted that door was badly damaged and paint scraped.

16. May 23, 2012 A resident room door was paint chipped.
- washroom door and door frame was badly damaged.
- vent in resident washroom was dusty.
- caulking at the base of the toilet was stained.

17. 1st Floor Clean Utility: May 23, 2012, Door scraped and damaged.

18. 1st Floor Nurses Station: May 22, 2012
Carpeting was badly stained.
Counters badly chipped with missing pieces of laminate strip, bare wood exposed
Door badly paint scraped.
Walls damaged

19. May 23, 2012 Attended a resident room:
- room walls paint chipped.
- baseboard was scuffed at wall corner by resident's bed.
- room door had chunks missing and paint scraped.
- closet doors, door and door frame damaged.
- washroom door and door frame damaged. Gouges in the door, and paint scraped off.
- toilet holder moved, and holes not filled in.
- paint on wall, was chipped at light switch.
- Dresser, surface water damaged and swollen. Surface was worn.
- bed side table was damaged on top surface.

[LTCHA, 2007, S.O. 2007, c.8, s.15.(2)(c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following subsections:

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;
(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;
(c) removal and safe disposal of dry and wet garbage; and
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. Reviewed policy and procedures for housekeeping. No policy or procedures for cleaning common areas eg, carpets in hallways or in nursing stations.

2. No policy or procedure for cleaning serveries.

[O.Reg. 79/10, s.87.(2)(a)(ii)]

1. Reviewed policy and procedures for housekeeping. Home was unable to provide documented evidence to support the home having policies and procedures for:
- cleaning of resident equipment

[O.Reg. 79/10, s.87.(2)(b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following subsections:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items;
(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents;
(c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours; and
(d) industrial washers and dryers are used for the washing and drying of all laundry. O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. Attended laundry room May 22, 2012 @ 3:25 pm. Laundry aide was asked what the process was regarding torn linens. The laundry aide shared that if items of linen are torn, they are discarded and recorded in the discard book, located on the clean side of the laundry room. Reviewed discard book. First date starts in April 2009, and run to Jan. 2010. Then from Jan. 2010 to Dec. 2010. The next entry is May 2012. No notation of laundry being discarded during 2011 or the first 4 months of 2012. No documented evidence to support damaged linens being removed from circulation for 2011 nor the first 4 months of 2012.

2. Attended a resident room May 22, 2012 @ 2:50 pm. Checked the sheets for a bed and found two areas along the side where there were holes in the bottom fitted sheet.

3. 2nd. Floor North Spa: May 24, 2012. Privacy curtain torn.

4. 2nd. Floor Clean Utility Room: May 23, 2012
- found 2 worn soaker pads on clean linen cart in the room.
- In the clean storage room, found 3 pillow cases with holes; 1 worn soaker pad; 3 fitted sheets with holes; 1 top sheet with holes; and 1 pillow with a cracked surface.

5. May 23, 2012- In a resident room @ 12:45 pm,noted a worn soaker pad on the bed. Housekeeping Aide confirmed the worn soaker pad, and promptly removed it, stating she would get another one.

[O.Reg. 79/10, s.89.(1)(c)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following subsections:

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
(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. Reviewed policy and procedures for maintenance.

No policy and procedures for preventive or remedial maintenance. For example, no policy or procedure for fixing damaged areas in resident rooms and common areas was provided. No policies or procedures were provided to support the painting program nor of repairs to rooms as residents vacate.

2. Environmental Services Supervisor confirmed @ 9:55 am May 25, 2012, that there was no policy or procedures for preventive or remedial maintenance.

[O.Reg. 79/10, s.90.(1)(b)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 29th day of June, 2012

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KARIN MUSSART (145)
Inspection No. / No de l'inspection :	2012_093145_0021
Type of Inspection / Genre d'inspection:	Other
Date of Inspection / Date de l'inspection :	May 22, 23, 24, 25, Jun 4, 12, 13, 19, 20, 21, 26, 27, 28, 2012
Licensee / Titulaire de permis :	RITZ LUTHERAN VILLA R.R. 5, MITCHELL, ON, N0K-1N0
LTC Home / Foyer de SLD :	RITZ LUTHERAN VILLA PART LOT 16, CON 2, LOGAN TWN, R.R. #5, MITCHELL, ON, N0K-1N0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	BOB PETRUSHEWSKY

To RITZ LUTHERAN VILLA, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(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).

Order / Ordre :

1. Prepare and submit a plan to the Inspector by July 18, 2012 which identifies and addresses the requirements that the home , furnishings and equipment are kept clean and sanitary and in a good state of repair. The plan must include the proposed time-lines by which the identified risks will be addressed and by when the identified areas will be cleaned/repaired.

The written plan shall be submitted to Karin Mussart, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 291 King St., 4th Floor, London, ON, N6B 1R8. Plan may be Faxed to (519) 675-7685 or emailed to LondonSAO.moh@ontario.ca.

Grounds / Motifs :

1. 2nd. Floor:
- walls scuffed by the elevator.
-walls across from Infection Control Practitioners office damaged.

2. 2nd. Floor Dining Room: wall surfaces scraped/damaged throughout the dining room. Wall corners damaged, and piece missing from corner wall protection. Baseboard pushed in at the corner across from the servery.

3. In a resident room:
- room and washroom doors and door frames chipped.
-washroom grab bar stained.

4. In a resident room:
-wall by bed rail damaged.
-comfortable chair legs and arms worn.
-washroom door and door frame badly chipped/damaged.
-chunk missing from washroom door.
-room door scraped/damaged.
-rough patching only done in washroom. Some damaged areas remain.
-booster seat on toilet, armrest covers were split.
-old toilet paper holder dirty and rusted.
-washroom walls paint chipped, old wall plugs left in.

5. Interior of Elevator: Paint chipped on doors, and wall surface was scraped.

6. Basement: Resident access corridor: Doors and door frames chipped for hair salon, and other rooms.

7. 2nd. Floor North Spa Room: at 2:02 pm, noted musty odour coming from the shower drain.
- door was paint chipped.
- wall corner at the entrance to the spa was damaged.
- washroom area had holes in the wall.
- baseboard pulling away from the wall beside toilet and beside shower.
- cinder block paint was chipped.

8. 2nd Fl. North Lounge: Blinds broken.

9. 2nd. Floor, all wings (North, East and West) carpeting was stained.

10. 2nd. Floor, East Wing Spa, cupboard door is delaminating with bare wood showing.
- doors were paint chipped.

11. Hole in the wall in hallway on 2nd. floor.

12. 2nd. Floor, all wings (North, East, and West) hallway walls paint was scraped or chipped and damaged.

13. 2nd. Floor East Lounge 2:30 pm: 2 brown chairs, stained on seating area.
- 3 green chairs stained on seating area.
- 5 chairs and 1 table have damaged legs.

14. 2nd Floor Nurses Station: counters are chipped; carpeting was worn and dirty. Door and outside walls were scraped/damaged.

15. In a resident room:
- Cupboard doors badly paint scraped.
- room walls badly chipped.
- room door has paint scraped and damage to surface.
- washroom door and door frames were paint chipped.
- grab bar behind the toilet had stains on surface.
- flooring in the washroom was stained.
- wall behind headboard damaged--holes in the wall.
- wall alongside the bedrail damaged---holes in the wall.
- wall behind the headboard damaged. Wall scraped near bedrail.

16. 1st Floor Dirty Utility Room
- noted that door was badly damaged and paint scraped.

17. In a resident room, the door was paint chipped.
- washroom door and door frame was badly damaged.
- vent in washroom was dusty.
- caulking at the base of the toilet was stained.

18. 1st Floor Clean Utility: door scraped and damaged.

19. 1st/2nd. Floor Nurses Station
-Carpeting was badly stained.

-Counters badly chipped with missing pieces of laminate strip, bare wood exposed
-Door badly paint scraped.
-Walls damaged

20. In a resident room:
- room walls paint chipped.
- baseboard is scuffed at wall corner by resident Barbour's bed.
- room door had chunks missing and paint scraped.
- closet doors, door and door frame damaged.
- washroom door and door frame damaged. Gouges in the door, and paint scraped off.
- toilet holder moved, and holes not filled in.
- paint chipped at light switch.
- dresser, surface water damaged and swollen. Surface is worn.
- bed side table for Barbour was damaged on top surface. (145)

2. 1st floor Dining Room:
Found 9 dining room chair seats stained.
-servery floor, dirt and debris on floor around equipment.
-dirt/debris underneath the hand sink.

2. 1st Floor South Lounge:
-carpet in lounge appeared dirty.

3. Main Kitchen:
-noted food debris on floor by ice machine. Found one dish under storage rack.

4. In a resident room a wheelchair was dirty with debris. Interviewed the resident, and the resident indicated that its not cleaned very frequently.

5. In a resident room, wheelchair seat cushion and belt very dirty.

6. Observed a resident wheelchair outside of the 2nd floor nurses station. The seat belt was dirty from food debris.

7. 2nd. Floor East Lounge: 2 brown chairs, stained on seating area.
- 3 green chairs stained on seating area.
- Maximove and Sara 3000 lifts stored in the lounge were dirty
- Wheelchair also stored in lounge had dirty seating area and foot rests.

8. 2nd. Floor North Spa: noted vent fan was dirty.

9. 2nd. floor Dining Room: 12/12 dining tables had worn surfaces that were sticky to the touch.

10. In a resident room, vent in washroom was dusty.

11. 2nd. Floor Hallways:, Noted numerous stains on the carpets throughout the entire carpeted area of 2nd. floor.

12. In the 2nd. Floor Dining Room:
- where metal transition strips have lifted, there was food debris underneath.
- grooves in the metal transition strips had dirt/debris in between them.
- counted 11 dining room chairs that were stained on the seating area.
- windows were dirty or covered in cobwebs.

- in the servery, the floor had a buildup of dirt/debris by the handsink.
- dirt/debris on floor underneath the counter overhand and around equipment in the servery.
- dried juice was found on the lower interior surface of the refrigerator.

13. In a resident room:
- comfortable chair stained on the seating surface.
- noted urine odor in room.
- toilet bowl had rust stains on inside surface.

14. Rm. #119
- vent cover in resident washroom was dusty. (145)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 03, 2012

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(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;
(c) removal and safe disposal of dry and wet garbage; and
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Order / Ordre :

1. Prepare and submit a plan to the Inspector by July 18, 2012 which identifies and addresses the requirements that the licensee ensure that policies and procedures are developed and implemented to ensure that resident, staff and common areas are cleaned. The plan must include the proposed time-lines by which the identified risks will be addressed.

The written plan shall be submitted to Karin Mussart, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 291 King St., 4th Floor, London, ON, N6B 1R8. Plan may be Faxed to (519) 675-7685 or emailed to LondonSAO.moh@ontario.ca.

Grounds / Motifs :

1. Home was unable to provide documented evidence of policies and procedures for cleaning of resident equipment. (145)
2. Home was unable to provide documented evidence of policies or procedures for cleaning common areas or staff areas, eg, carpets in hallways or in nursing stations.

Home was unable to provide documented evidence of policies or procedures for cleaning serveries. (145)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 03, 2012

Order # / Ordre no : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items;
(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents;
(c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours; and
(d) industrial washers and dryers are used for the washing and drying of all laundry. O. Reg. 79/10, s. 89 (1).

Order / Ordre :

1. Prepare and submit a plan to the Inspector by July 18, 2012 which identifies and addresses the requirements that the linen be maintained in a good state of repair. The plan must include the proposed time-lines by which the identified items will be addressed.

The written plan shall be submitted to Karin Mussart, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 291 King St., 4th Floor, London, ON, N6B 1R8. Plan may be Faxed to (519) 675-7685 or emailed to LondonSAO.moh@ontario.ca.

Grounds / Motifs :

1. Laundry aide was asked what the process was regarding torn linens. The laundry aide shared that if items of linen are torn, they are discarded and recorded in the discard book, located on the clean side of the laundry room. Reviewed discard book. First date starts in April 2009, and run to Jan. 2010. Then from Jan. 2010, to Dec. 2010. The next entry is May 2012. No notation of laundry being discarded during 2011 or the first 4 months of 2012. No documented evidence to support damaged linens being removed from circulation. Interviewed a second laundry aide, and she advised that she made the entry in the log book for May 2012.

2. In a resident room,checked the sheets on a bed, and found two areas along the side where there were holes in the bottom fitted sheet.

3. 2nd. Floor North Spa: Privacy curtain torn .

4. May 24, 2012 - 11:12 2nd. Floor Clean Utility Room
-- found 2 worn soaker pads on clean linen cart in the room.
- In the clean storage room, found 3 pillow cases with holes; 1 worn soaker pad; 3 fitted sheets with holes; 1 top sheet with holes; and 1 pillow with a cracked surface.

5. In a resident room, noted a worn soaker pad on bed. Housekeeping Aide confirmed the worn soaker pad, and promptly removed it, stating she would get another one. (145)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 03, 2012

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 004

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

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

Order / Ordre :

1. Prepare and submit a plan to the Inspector by July 18, 2012 which identifies and addresses the requirements that there are to be schedules and procedures for routine, preventive and remedial maintenance. The plan must include the proposed time-lines by which the identified risks will be addressed.

The written plan shall be submitted to Karin Mussart, Long-Term Care Homes Inspector, Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch, 291 King St., 4th Floor, London, ON, N6B 1R8. Plan may be Faxed to (519) 675-7685 or emailed to LondonSAO.moh@ontario.ca.

Grounds / Motifs :

1. Home was unable to provide documented evidence of policies and procedures for preventive or remedial maintenance. For example, no policy or procedure for fixing damaged areas in resident rooms and common areas. No policy or procedure describing a painting program or of repairs to rooms as residents vacate.

2. Environmental Services Supervisor confirmed that there were no policies or procedures for preventive or remedial maintenance. (145)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Aug 03, 2012

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Avenue West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au :

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
55, avenue St. Clair Ouest
8e étage, bureau 800
Toronto (Ontario) M4V 2Y2
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 28th day of June, 2012

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : KARIN MUSSART

Service Area Office /
Bureau régional de services : London Service Area Office

Ontario

Ministry of Health and Long-Term Care

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

Ministére 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, 4iém étage
LONDON, ON, N6B-1R8
Téléphone: (519) 675-7680
Télécopieur: (519) 675-7685

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
May 22, 23, 24, 25, Jun 4, 12, 13, 19, 20, 21, 26, 27, 28, 2012	2012_093145_0021	Other

Licensee/Titulaire de permis

RITZ LUTHERAN VILLA
R.R. 5, MITCHELL, ON, N0K-1N0

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

RITZ LUTHERAN VILLA
PART LOT 16, CON 2, LOGAN TWN, R.R. #5, MITCHELL, ON, N0K-1N0

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

KARIN MUSSART (145)

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 Environmental Services Supervisor; Director of Care; Acting CEO; 3 Health Care Aides; and 5 residents.

During the course of the inspection, the inspector(s) Conducted other inspection L-000769-12. This inspection was done concurrently with an RQI inspection 2012-087128-0010, Log # L-000691-12; toured all resident and common areas of the home;reviewed policy and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Accommodation Services - Maintenance

Findings of Non-Compliance were found during this inspection.

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.) 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 subsections:

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;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(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. 1st floor Dining Room:
-Found 9 dining room chair seats stained.
-servery floor, dirt and debris on floor around equipment.
-dirt/debris underneath the hand sink.

2. 1st Floor South Lounge:
-carpet in lounge appeared dirty.

3. Main Kitchen: May 24, 2012
-noted food debris on floor by ice machine. Found one dish under storage rack.

4. A resident wheelchair was found to be dirty with noticeable debris. Resident confirmed that the wheelchair was not being cleaned very frequently.

5. A resident wheelchair seat cushion and belt was found to be very dirty.

6. Resident wheelchair outside of the 2nd floor nurses station had a seat belt that was dirty from food debris.

7. 2nd. Floor East Lounge: 2 brown chairs, stained on seating area.
- 3 green chairs stained on seating area.
- Maximove and Sara 3000 lifts stored in the lounge were dirty
- Wheelchair also stored in lounge has dirty seating area and foot rests.

8. 2nd. Floor North Spa: noted vent fan cover was dirty.

9. 2nd. floor Dining Room: 12/12 dining tables had worn wooden surfaces that were sticky to the touch.

10. In a resident washroom, fan vent cover was covered in dust.

11. 2nd. Floor Hallways: Noted numerous stains on the carpets throughout the entire carpeted area of 2nd. floor. Also, the carpet in the Nurses stations on both 1st and 2nd. Floor.

12. 2nd. Floor Dining Room: May 24, 2012
- where metal transition strips have lifted, there was food debris underneath.
- grooves in the metal transition strips were found to have had dirt/debris in between them.
- counted 11 dining room chairs that were stained on the seating area.
- windows were dirty or covered in cobwebs.
- in the servery, the floor had a buildup of dirt/debris by the hand sink.
- dirt/debris was on the floor underneath the counter overhang and around equipment in the servery.
- dried juice was found on the lower interior surface of the refrigerator.

13. In a resident room:
- a comfortable chair was stained on the seating surface.
- noted urine odor in room.
- toilet bowl had rust stains on inside surface.

14. In a resident washroom, the fan vent cover was dusty.

[LTCHA, 2007, S.O. 2007, c.8, s.15.(2)(a)]

1. Second Floor: May 24, 2012 @ 10:25 am.
- walls scuffed by the elevator.

-walls across from Infection Control Practitioners office damaged.

2. 2nd. Floor Dining Room: May 24, 2012, wall surfaces scraped/damaged throughout the dining room. Wall corners damaged, and piece missing from corner wall protection. Baseboard was pushed in at the corner across from the servery.

3. In a resident room, May 24, 2012 @10:35 am
- room and washroom doors and door frames chipped.
-washroom grab bar stained.

4. In a resident room, May 24 ,2012 @ 10:30 am
-wall by bed rail damaged.
-comfortable chair legs and arms worn.
-washroom door and door frame badly chipped/damaged.
-chunk missing from washroom door.
-room door scraped/damaged.
-damaged walls in the washroom.
-booster seat on toilet, armrest covers were split.
-old toilet paper holder was found to be dirty and rusted.
-washroom walls paint chipped,with old wall plugs left in.

5. Interior of Elevator: Paint chipped on doors, and wall surfaces are scraped.

6. Basement: Resident access corridor: Doors and door frames chipped for hair salon, and other rooms.

7. 2nd. Floor North Spa Room: noted musty odour coming from the shower drain.
- door was paint chipped.
- wall corner at the entrance to the spa was damaged.
- washroom area had holes in the wall.
- baseboard pulling away from the wall beside toilet and beside shower.
- cinder block paint was chipped.

8. 2nd Fl. North Lounge: Blinds broken.

9. 2nd. Floor, East Wing Spa, cupboard door is delaminating with bare wood showing.
- doors were paint chipped.

10. Hole in the wall in hallway on 2nd. floor, May 24, 2012.

11. 2nd. Floor, all wings (North, East, and West) hallway walls, paint was scraped or chipped and damaged.

12. 2nd. Floor East Lounge: May 24, 2012
- 5 chairs and 1 table had damaged legs.

13. 1st and 2nd Floor Nurses Station: counters were chipped and dirty. Door and outside walls were scraped/damaged.

14. Attended a resident room on May 23, 2012 @ 2:49 pm.
- Cupboard doors badly paint scraped.
- room walls badly chipped.
- room door had paint scraped and damage to surface.
- washroom door and door frame had paint chipped.
- grab bar behind the toilet had stains on surface.

- flooring in the washroom was stained.
- wall behind headboard damaged--holes were noted in the wall.
- wall alongside the bedrail damaged---holes were noted in the wall.
- wall behind the headboard damaged. Wall scraped near bedrail.

15. 1st Floor Dirty Utility Room: May 23, 2012 @ 3:00 pm, noted that door was badly damaged and paint scraped.

16. May 23, 2012 A resident room door was paint chipped.
- washroom door and door frame was badly damaged.
- vent in resident washroom was dusty.
- caulking at the base of the toilet was stained.

17. 1st Floor Clean Utility: May 23, 2012, Door scraped and damaged.

18. 1st Floor Nurses Station: May 22, 2012
Carpeting was badly stained.
Counters badly chipped with missing pieces of laminate strip, bare wood exposed
Door badly paint scraped.
Walls damaged

19. May 23, 2012 Attended a resident room:
- room walls paint chipped.
- baseboard was scuffed at wall corner by resident's bed.
- room door had chunks missing and paint scraped.
- closet doors, door and door frame damaged.
- washroom door and door frame damaged. Gouges in the door, and paint scraped off.
- toilet holder moved, and holes not filled in.
- paint on wall, was chipped at light switch.
- Dresser, surface water damaged and swollen. Surface was worn.
- bed side table was damaged on top surface.

[LTCHA, 2007, S.O. 2007, c.8, s.15.(2)(c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following subsections:

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;
(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;
(c) removal and safe disposal of dry and wet garbage; and
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. Reviewed policy and procedures for housekeeping. No policy or procedures for cleaning common areas eg, carpets in hallways or in nursing stations.

2. No policy or procedure for cleaning serveries.

[O.Reg. 79/10, s.87.(2)(a)(ii)]

1. Reviewed policy and procedures for housekeeping. Home was unable to provide documented evidence to support the home having policies and procedures for:
- cleaning of resident equipment

[O.Reg. 79/10, s.87.(2)(b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following subsections:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items;
(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents;
(c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours; and
(d) industrial washers and dryers are used for the washing and drying of all laundry. O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. Attended laundry room May 22, 2012 @ 3:25 pm. Laundry aide was asked what the process was regarding torn linens. The laundry aide shared that if items of linen are torn, they are discarded and recorded in the discard book, located on the clean side of the laundry room. Reviewed discard book. First date starts in April 2009, and run to Jan. 2010. Then from Jan. 2010 to Dec. 2010. The next entry is May 2012. No notation of laundry being discarded during 2011 or the first 4 months of 2012. No documented evidence to support damaged linens being removed from circulation for 2011 nor the first 4 months of 2012.

2. Attended a resident room May 22, 2012 @ 2:50 pm. Checked the sheets for a bed and found two areas along the side where there were holes in the bottom fitted sheet.

3. 2nd. Floor North Spa: May 24, 2012. Privacy curtain torn.

4. 2nd. Floor Clean Utility Room: May 23, 2012
- found 2 worn soaker pads on clean linen cart in the room.
- In the clean storage room, found 3 pillow cases with holes; 1 worn soaker pad; 3 fitted sheets with holes; 1 top sheet with holes; and 1 pillow with a cracked surface.

5. May 23, 2012- In a resident room @ 12:45 pm,noted a worn soaker pad on the bed. Housekeeping Aide confirmed the worn soaker pad, and promptly removed it, stating she would get another one.

[O.Reg. 79/10, s.89.(1)(c)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following subsections:

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
(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. Reviewed policy and procedures for maintenance.

No policy and procedures for preventive or remedial maintenance. For example, no policy or procedure for fixing damaged areas in resident rooms and common areas was provided. No policies or procedures were provided to support the painting program nor of repairs to rooms as residents vacate.

2. Environmental Services Supervisor confirmed @ 9:55 am May 25, 2012, that there was no policy or procedures for preventive or remedial maintenance.

[O.Reg. 79/10, s.90.(1)(b)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 29th day of June, 2012

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