



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

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

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Hamilton Service Area Office
119 King Street West, 11th Floor
Hamilton ON L8P 4Y7

Bureau régional de services de Hamilton
119, rue King Ouest, 11^{ième} étage
Hamilton ON L8P 4Y7

**Ministère de la Santé et des Soins de
longue durée**

Division de la responsabilisation et de la performance du
système de santé
Direction de l'amélioration de la performance et de la
conformité

Telephone: 905-546-8294
Facsimile: 905-546-8255

Téléphone: 905-546-8294
Télécopieur: 905-546-8255

☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
December 14 & 16, 2010	2010-120-2908-16DEC081928	H-03005 Follow-up to Dec. 9 & 10, 2009
Licensee/Titulaire		
Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner, 100 Milverton Drive, Suite 700, Mississauga, ON, L5R 4H1		
Long-Term Care Home/Foyer de soins de longue durée		
The Waterford LTC, 2140 Baronwood Drive, Oakville, ON, L6M 4V6		
Name of Inspector(s)/Nom de l'inspecteur(s)		
Bernadette Susnik, LTC Homes Inspector – Environmental Health #120		
Inspection Summary/Sommaire d'inspection		
The purpose of this visit was to conduct a follow-up inspection to previously issued non-compliance made under the Ministry of Health and Long-Term Care Homes Program Standards Manual with respect to the following unmet criterion; • O2.1 (Maintenance Program) During the course of the inspection, the above noted inspector spoke with the administrator, corporate environmental services consultant, director of care, maintenance personnel, housekeeping and nursing staff. During the course of the inspection, the inspector conducted a walk-through of the building and inspected resident rooms and their ensuite washrooms, common areas, dining rooms, serveries, bathing rooms and utility rooms. The nurse call system was tested, hot water temperatures taken and several housekeepers were monitored during their cleaning routines. The following Inspection Protocols were used: • <i>Safe and Secure Home</i> • <i>Accommodation Services – Maintenance</i> • <i>Infection Prevention and Control</i> ☒ Findings of Non-Compliance were found during this inspection. The following action was taken: 4 WN 4 VPC		

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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 suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN#1: The licensee has failed to comply with O. Reg. 79/10, s. 229(4). The licensee shall ensure that all staff participate in the implementation of the program.

Findings:

Staff members are not participating in the infection prevention and control program, which includes the prevention or the elimination of the spread of disease through hand-hygiene and cleaning and disinfection principles. The following observations were noted;

1. The home's policies and procedures require staff to remove gloves after giving care and to perform hand hygiene. Two staff members were observed carrying a bundle of soiled linen down the corridor with gloves on and they contaminated the door and door knob as they entered the Mud room to dispose of the linen. Gloves were removed in the Mud room and no hand hygiene took place.
2. Cleaning and sanitizing of re-useable devices such as bedpans and washbasins are not being conducted after each use, preventing the spread of micro-organisms. The home's policy requires staff to clean these items 2x per week, which does not meet the principle of preventing infections. 5 washbasins and 2 bedpans were found in resident's ensuite washrooms with residues on their surfaces.
3. 2 housekeeping staff were observed during their resident room cleaning routines. Neither housekeeper followed infection control basics, in reducing the risk of cross-contamination during the cleaning process. Contaminated surfaces such as toilets and sinks were cleaned before bedroom surfaces and touch point surfaces. When touch point surfaces were cleaned, very little disinfectant was poured onto the cloths so that the surfaces could remain wet for at least the minimum 5-10 minute contact time required by the disinfectant manufacturer. One housekeeper did not use disinfectant on the surfaces in the resident's bedroom. Housekeeping staff did not consistently conduct hand hygiene between "dirty" (toilet cleaning) and "clean" tasks (dusting furniture).
4. The full length tubs (from T.H.E Medical) in the home no longer function as they were originally designed. The jet holes were plugged several years ago and the built-in disinfection system can no longer be used. In it's place, staff have been given spray bottles called "Everyday Disinfectant", containing a disinfectant that is not at the same concentration as the automatically dispensed solution. In addition, the spray bottles do not dispense an adequate amount of liquid onto tub surfaces and is applied inconsistently from person to person. Cleaning directions have not been amended since the tub jet holes were plugged.

Additional Required Action:

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 with s.229(4) in respect to ensuring that staff participate in the implementation of the program, to be implemented voluntarily.

WN #2: The licensee has failed to comply with the LTCHA, 2007, S.O. 2007, c.8, s.15(2)(a) & (c). Every licensee of a long-term care home shall ensure that,

- (a) the home, furnishings and equipment are kept clean and sanitary; and
- (c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

Findings:

1. Flooring material in each of the serveries is not in good condition. Flooring is cracked along the wall/floor junction. The flooring material is ripped under a bed in an identified resident room. Water has seeped under the flooring material in the Bronte shower room at the junction between the tiled area and the vinyl flooring material. (**Previously issued as Criterion O2.1 under the MOHLTC Homes Program Standards Manual.**)
2. Light covers missing from a number of light fixtures located in resident washrooms or their bedrooms.
3. Some of the toilets are leaking water down from the toilet tank into the toilet bowl.
4. The exhaust grilles are thick with dust in some of the resident ensuite washrooms in the Palermo home area.
5. Walls were visibly soiled in several resident rooms/washrooms in the Palermo home area over the course of several days.

Additional Required Action:

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 with s.15(2)(a) & (c) in respect to ensuring that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair and that the home, furnishings and equipment are kept clean and sanitary, to be implemented voluntarily.

WN #3: The licensee has failed to comply with O. Reg. 79/10, s. 17(1)(f). Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that, (f) clearly indicates when activated where the signal is coming from.

Findings:

8 PSWs were not wearing their nurse call pagers on December 16th. Wearing the pager is an essential component in determining the source of the signal when staff are not in close proximity to the nursing station (where a desk phone is located which displays the room number and an alarm sounds). Pagers #4030, 4032 & 4009 were sent out for repair and no spare pagers were available in the home. Pagers #4028 and 4010 were found at the nurse's desk, without a battery. Pagers #4016, 4024 and 4026 were found at the nurse's desk, fully functional and not being worn by the psWs, all of which were on duty.

A resident was observed pulling on the nurse call station in their bathroom at 10:00 a.m. on Dec. 16th. Two psWs, neither carrying a pager, walked past the room, where above the door, a light was activated. Neither psW attended to the resident. A third psW responded at 10:04 a.m., who did not have her pager. She did not know that this resident needed assistance until she walked past the nursing station where the nurse call

system had sounded.

The home instituted a pager assignment log, requiring staff to sign for their pagers at the beginning of their shift and to sign them out at the end of their shift. These logs were noted to be mostly blank, indicating that the staff are not signing out their pagers and not monitored in any way to ensure they are carrying their pagers.

Additional Required Action:

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 with s.17(1)(f) in respect to ensuring that home is equipped with a resident-staff communication and response system that clearly indicates when activated where the signal is coming from, to be implemented voluntarily.

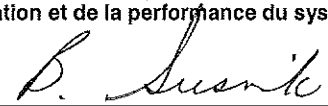
WN #4: The licensee has failed to comply with O. Reg., 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

Findings:

The residents who reside in the Sheridan home area, in the short corridor are not able to rest or sleep during periods throughout the daytime due to excessive noise coming from an identified resident room. The noise level from a 40+ inch television screen located in this room was abnormally loud, disturbing many other residents in the home area dedicated to behaviours. Within this resident room, the sound of a raised human voice could not be heard. In the rooms adjacent to this resident room, the sound of the television set drowned out normal conversation. The nursing staff have indicated that the resident resists their repeated attempts to lower the volume of the television. This intervention has not been successful and the home did not present any other plans to address the concern at the time of inspection.

Additional Required Action:

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 with s. 41 in respect to ensuring that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep.

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné	Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé. 
Title: _____ Date: _____	Date of Report: (if different from date(s) of inspection). Feb. 4/11