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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

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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
Mar 23, 2016	2016_461552_0005	004042-16	Resident Quality Inspection

Licensee/Titulaire de permis

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

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

BAY RIDGES
900 SANDY BEACH ROAD PICKERING ON L1W 1Z4

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

MARIA FRANCIS-ALLEN (552), CAROLINE TOMPKINS (166), DENISE BROWN (626), JULIET MANDERSON-GRAY (607), PATRICIA MATA (571), SARAH GILLIS (623)

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): February 16, 17, 18, 19, 22, 23, 24, 25, 26, 29, March 1 & 2, 2016

Follow up log # 029601-15 related to abuse, Complaint log # 012423-15 related to medication administration, #024328-15 related to abuse, #027024-15 related to bowel care, # 001422-16 related to discharge process, Critical Incident log # 005182 -15, 014896-15, 015645-15, 016676-15 related to responsive behaviors, # 006048-15, 0115720-15, 000360-15 related to abuse, # 026472-15 & 036242-15 related to falls, # 029794-15 related to entrapment and # 004638-16 related to medication administration were inspected concurrently.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Associate Director of Care (ADOC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW), Resident Council, residents and family members.

The inspectors toured the home, observed interactions between staff and residents during the dining service and administration of medication, reviewed clinical health records and the licensee's policies related to: Abuse, Responsive Behaviors, Falls Prevention, Infection Control, Minimizing Restraints and Resident Council minutes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Laundry
Admission and Discharge
Continence Care and Bowel Management
Critical Incident Response
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Resident Charges
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
6 WN(s)
0 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2015_328571_0009	552

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. 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 failed to ensure that all staff participates in the implementation of the infection prevention and control program.

During the Resident Quality Inspection, observations pertaining to infection prevention and control were made by inspectors #552, #571 and #623. These observations included several residents rooms with “Contact Precaution” signs on the door indicating that staff should wear gloves and gowns when providing care. Several staff members were observed entering and exiting these rooms before and after care wearing only gloves.

On March 2, 2016, every resident room in the home was observed for “Contact Precaution” signs. Fifteen rooms on three different units were noted to have a sign.

On March 2, 2016, a report listing all residents currently active with antibiotic resistant organisms (AROs) was provided by the ADOC. This report contained 26 residents currently colonized or infected. The residents on these lists were compared to the rooms with “Contact Precaution” signs on the door and ten rooms were missing the signs.

In addition, two additional residents were identified by inspector #571 to be colonized with ARO when lab results were reviewed.

In separate interviews on February 18, 2016, PSW #120 indicated the resident in an identified room has ARO but did not know which one and only wore gloves during direct care. PSW #111 provided direct care to the resident in another identified room wears only gloves. When asked if he/she was supposed to wear a gown during care, he/she stated “I don't know that”. PSW #109 indicated that neither of the two residents in another identified room was on contact precautions despite the “Contact Precaution” sign on the door being brought to the staff's attention by inspector #571. PSW #120 and #111 indicated that isolation gowns are stored in a room located in the west hallway.

In an interview on February 22, 2016, PSW #108 indicated that he/she wears gloves when providing direct care to the resident in an identified room but would get an isolation

gown if they were changing a “messy” bowel movement. A contact precaution sign on the door indicated gloves and gowns should be worn when providing care.

In an interview on February 23, 2016, PSW #106 indicated that the residents in an identified room were not under contact precautions. When Inspector #571 brought the “Contact Precaution” sign to the staff's attention, PSW #106 indicated the sign must be new and asked RPN #101 for confirmation. RPN #101 indicated the contact precautions for that room was not new but was unable to tell Inspector #571 which resident was under precautions and would have to look in the both residents’ clinical health records. RPN #101 indicated the PSW’s would know which resident was under precautions by looking at the resident’s kardex. The resident's kardex indicated:
- Follow Additional Precautions/Contact Precautions as per signage on door
- Resident is in a semi-private room; Ensure hygiene and toileting products are in a dedicated area.

In an interview on March 2, 2016, RPN #131 indicated that one resident was on contact precautions for an identified condition. Inspector #571 inquired why a contact precaution sign was not on the resident’s door; RPN #131 explained that sometimes residents remove the signage.

In an interview on March 2, 2016, PSW #100 indicated there were currently no residents on the unit on contact precaution and that when residents are on contact precaution, there is the contact precaution signage on the door and sometimes a yellow bag containing PPE.

In an interview on March 2, 2016, RPN #133 indicated that the resident in identified rooms are on contact precautions and showed the inspector the report sheet that indicated this information. RPN #133 informs the PSW’s during report of any residents who are on contact precautions.

The DOC indicated in an interview on March 1, 2016, that she has been working closely with Public Health Officer (PHO) #132 over the past two years to reduce the number of residents diagnosed with an identified infection. The DOC indicated that PHO #132 informed the DOC that gowns only have to be worn if staff were going to be in direct contact with the source of the infection/colonization. The DOC indicated that when staff change an incontinent product, they were not at risk for coming into direct contact with the source of the identified infection/colonization. The DOC and ADOC are on the infection control team and they decide if staff are going to be at risk for direct contact with

the source of infection/colonization. If they determine that isolation gowns are necessary, then either the DOC or the ADOC hang a yellow isolation bag on the door that contains isolation gowns in addition to a "Contact Precaution" sign. Therefore, if a yellow bag is absent from the door and a "Contact Precaution" sign is present, staff only need to wear gloves during direct care.

In a telephone interview on March 1, 2016, PHO #132 indicated that a couple years ago she had provided recommendations regarding surveillance and infection prevention and control measures that should be in-place at the LTCH to prevent transmission of infections to other residents and staff. She indicated that the LTCH was advised gowns and gloves should be worn when providing direct care, to a resident who is infected or colonized with any ARO.

A review of the licensee's policy IPC-B-20 entitled Additional Precautions –Contact Precaution revised August 2015 indicates that gloves and gowns should be worn for direct care/contact including bathing, washing and continence care and any necessary personal protective equipment is to be available at point of care.

Therefore, the licensee failed to ensure that all staff participate in the implementation of the home's Infection Prevention and Control program by failing to ensure that: all staff wore appropriate personal protective equipment when providing direct care to a resident under contact precautions and that gowns were available at point of care; all residents with ARO's were tracked; signage alerting staff and visitors to use contact precautions were in place for all residents identified with ARO. [s. 229. (4)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was provided to resident #018 as specified in the plan.

A review of the clinical record indicates resident #018 uses a mobility device and requires assistance to toilet.
The current care plan indicates that resident #018 is on a toileting schedule plan.

In an interview on February 18, 2016, a family member for resident #018 indicated the resident was not always toileted as per the schedule. The family member visits daily and has kept a record of the times when the resident is toileted; specifically after lunch.

In an interview on February 19, 2016, PSW #110 who was assigned to resident #018 on day shift, indicated that resident #018 is on a toileting schedule in the morning only and then as necessary when resident #018 asks for assistance. On February 22, 2016, PSW #108 indicated in an interview that resident #018 is toileted in the morning then at 1045hrs and 1445hrs - this staff member's shift ends at 1430hrs and is not present to observe if the resident is toileted as outlined in the schedule.

In an interview with RN #104 who is the full time staff on the unit indicated the resident should be toileted at the hour specified on the care plan which includes after lunch.

During observations on February 18, and 19, 2016, Inspector #571 was present on the unit after lunch until 1430hrs and did not observe resident #018 being toileted.

Therefore, the licensee failed to ensure that resident #018 was toileted as outlined in the current plan of care. [s. 6. (7)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Re: Log #026472-15

A Critical Incident Report (CIR) was received by the Director on an identified date for – fall with injury during a transfer for resident #058 that occurred three days earlier.

On an identified date the clinical record indicated that resident #058 was being assisted with personal care by PSW# 108. After completing personal care, PSW #108 prepared to transfer the resident into the mobility device. PSW# 108 turned away from resident #058 to reach for an item and the resident fell forward out of the chair; the resident sustained minor injuries.

The home's policy #LTC-K-80 – Safety - Bath Lifts, Tub Chairs and Shower Commodes last revised August 2012 under National Operating Procedure states:

- Seatbelts/protective bar will be applied at all times while resident is sitting in the bathing chair. Breaks will be engaged during the lift, lowering and transferring process.
- Two staff members will be present during the lift and lowering of a resident in a mechanical bathing device. The resident will not be left unattended at any time.
- Mechanical bathing devices will be placed in the lowest position after removing resident from the tub and prior to drying the resident.

Review of resident #058's clinical health record for plan of care indicated that resident #058 required a mechanical lift with two person assist for bathing. For transfers resident #058 required a mechanical lift with a specific sling, and two staff full support to transfer safely.

During an interview on February 29, 2016 PSW #108 confirmed that the details outlined in the CIR and that he/she did not use safe transferring and positioning devices or techniques when assisting the resident.(623) [s. 36.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that actions were taken to meet the needs of resident #057 who had responsive behaviours specifically assessments, reassessments, interventions and documentation of the resident's responses to the interventions.

Re: Log # 000360-16:

The licensee forwarded a complaint to the Director that was received from the family of resident #057 alleging abuse by a staff member towards resident #057.

A review of the licensee's investigation records indicated that during separate interviews, PSW #126, RPN #101, PSW #127, PSW #128, PSW #106 and RPN #129 indicated that resident #057 exhibited verbal responsive behaviours towards staff. Also, the investigation records indicated that PSW #126 does not provide care to resident #057 anymore because of the resident's behaviours and PSW #128 will try to trade the resident off his/her assignment as he/she is afraid to enter resident #057's room.

In an interview on February 29, 2016, PSW #106 indicated that resident #057 exhibited verbal responsive behaviours towards staff and that the behaviour worsened after a room change as the resident was not happy with this arrangement. PSW #106 indicated that he/she has not witnessed any staff member being abusive towards the resident.

In an interview on February 29, 2016, PSW #130 indicated that resident #057 exhibited verbal responsive behaviours several times per week to staff and sometimes attempts physical responsive behaviours. When this happens, PSW #130 leaves and re-

approaches a short time later. PSW #130 was unable to identify any triggers for this behaviour.

In an interview on February 29, 2016, PSW #126 indicated that resident #057 has been verbally abusive and that informed the nurse on an identified date, that he/she would no longer provide care for resident #057. PSW #126 denies verbally or physically abusing resident #057 or witnessing any co-workers abusing the resident.

In an interview on February 24, 2016, RPN #101 indicated that resident #057 exhibits verbal responsive behaviours towards staff when he/she is displeased or mad. RPN #101 was able to identify the behavioural triggers for the resident. The staff member indicated the resident's behaviours would not be captured in the quarterly assessment, as they only document new behaviours in the assessment. The resident's behaviours are ongoing and should be captured in the care plan.

The clinical records for resident #057 were reviewed. Documentation regarding responsive behaviours could not be found in the progress notes for a three month period. A review of the care plan indicated under "Focus" that resident #057 exhibits responsive behaviour specifically verbal abuse due to impatience and interventions were implemented. However, the focus and interventions for responsive behaviours were documented as resolved over a year ago, even though according to staff the resident continued to exhibit responsive behaviours.

Review of the most recent quarterly assessment indicates the behaviors exhibited by the resident were not being documented so there are no care plan interventions that address this behaviour.

Therefore, the licensee failed to ensure that resident #057 who was demonstrating responsive behaviours was assessed, reassessed, strategies developed and redeveloped and actions taken. [s. 53. (4) (c)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3.1) Where an incident occurs that causes an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee shall,
(a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and
(b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident, and follow with the report required under subsection (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that where an incident has occurred that caused an injury to a resident for which the resident is taken to a hospital, but the licensee is unable to determine within one business day whether the injury has resulted in a significant change in the resident's health condition, the licensee failed to:

a) contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition; and

b) where the licensee determines that the injury has resulted in a significant change in the resident's health condition or remains unsure whether the injury has resulted in a significant change in the resident's health condition, inform the Director of the incident no later than three business days after the occurrence of the incident.

Re: Log #004638-16

A CIR was submitted to the Director on an identified date for an incident that occurred five days earlier where resident #053 choked while receiving oral medications and was transferred to the hospital for assessment.

A review of the homes incident investigation, clinical records for resident #053 including

progress notes and staff interviews with RPN #102 indicated that on an identified date, RPN #102 was administering medications to resident #053 as directed. At the time of administration the resident began to choke; the staff member provided interventions. Once the resident began to cough, the RPN then paged for help. RN #119 arrived as well as RPN #101 from the neighbouring unit. They provided further care to the resident. RPN #102 called the doctor to explain the situation and called 911 to transfer to hospital for assessment.

The clinical records indicate later that day, staff called the hospital for an update and was informed the resident is currently stable awaiting further direction from MD. A staff member later called the POA and was informed the resident would be admitted for a few days for monitoring. The following documentation was found:

- On an identified date staff spoke with POA regarding status of the resident and was informed that there is currently no discharge date.

- Five days later, staff spoke to POA who informed the staff member that at this point, resident's condition is deteriorating and that the resident is now being provided with comfort measures.

-Four days later staff received a call from residents’ sister stating that resident is not returning to the home.

During an interview with RPN #107 inspector #623 asked if there were any attempts to contact the hospital for information on the status of resident #053. RPN #107 stated "You try and try and they never answer, or the nurse is on break. "I probably did but I know that the family was a better resource." RPN #107 could not say for certain if he/she had attempted to contact the hospital for updates on the residents condition and agreed that there was no documentation to indicate that he/she had. RPN #107 could also not remember the date when management was told that there was a change in the resident's health status but could confirm that on an identified date, the POA indicated a significant change had occurred in the resident.

During an interview with the DOC and ADOC, it was confirmed that when a resident is transferred to the hospital it is the homes expectation that when updates are received, staff are to document in the clinical record in the electronic system, as well as any attempts to contact the hospital where staff are unable to obtain an update. The DOC confirmed that there is no documentation to indicate that the home attempted to contact

the hospital to determine the status of the resident within three calender days. DOC also confirmed that based on the documented information in the clinical record that was received from the POA, it could be determined that a significant change had occurred in resident #053 and a report to the Director should have occurred.

Therefore the home failed to contact the hospital within three calendar days after the occurrence of the incident to determine whether the injury has resulted in a significant change in the resident's health condition. The home also failed to notify the Director once they became aware of the significant change in the residents condition on an identified date. [s. 107. (3.1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Findings/Faits saillants :

1. Related to Log #001422-16

The licensee has failed to ensure that before discharging resident #041, (a) alternatives to discharge have been considered (b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident;
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration.

On an identified date, the licensee sent a letter to resident #041's substitute decision maker, indicating that resident #041, who had been admitted to the hospital three days earlier was discharged from the home effective immediately.
The ED indicated,that alternatives to discharge, collaboration with the appropriate placement co-ordinator to make alternate arrangements and contact with the resident or resident's substitute decision maker in order to provide an opportunity to participate in the discharge planning did not occur. [s. 148. (2)]

Issued on this 29th day of March, 2016

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

Original report signed by the inspector.

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de sions de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MARIA FRANCIS-ALLEN (552), CAROLINE TOMPKINS (166), DENISE BROWN (626), JULIET MANDERSON-GRAY (607), PATRICIA MATA (571), SARAH GILLIS (623)
Inspection No. / No de l'inspection :	2016_461552_0005
Log No. / Registre no:	004042-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 23, 2016
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	BAY RIDGES 900 SANDY BEACH ROAD, PICKERING, ON, L1W-1Z4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Andrea DeLuca

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee is hereby ordered to ensure the following:
- all staff interacting with residents or their environment will be made aware of residents who are on contact precautions and the source of the colonization or infection.
-all staff will be re-educated on the licensee's policy # IPC-B-20, IPC-D-10, IPC-D-10--ON and IPC-B-10
- all staff will perform risk assessment prior to every interaction with each resident on contact precautions and determine the appropriate personal protective equipment (PPE).
- a supply of all potentially required PPE is available at the point of care so that staff can select the appropriate PPE based on that risk assessment, without delay.
-the home will accurately complete their tracking and surveillance tool as per IPC-D-10-ON
-all residents identified as colonized or infected with an Antibiotic Resistant Organism (ARO) will have contact precaution signage in place or where this is impossible another means of identifying residents on contact precaution as per the licensee's policy is to be used
-the infection control co-ordinator will access local resources such as the Regional Infection Control Network (RICN) and/or Public Health Unit (PHU) for guidance and education for best practices for managing AROs in the home.

Grounds / Motifs :

1. The licensee failed to ensure that all staff participates in the implementation of the infection prevention and control program.

During the Resident Quality Inspection, observations pertaining to infection prevention and control were made by inspectors #552, #571 and #623. These

observations included several resident rooms with "Contact Precaution" signs on the door that indicated staff should wear gloves and gowns when providing direct care. Several staff members were observed entering and exiting these rooms before and after care wearing only gloves.

On March 2, 2016, every room was observed for "Contact Precaution" signs. Fifteen rooms on three different units were noted to have a sign.

On March 2, 2016, a report listing all residents currently active with antibiotic resistant organisms (AROs) was provided by the ADOC. This report contained 26 residents currently colonized or infected . The residents on these lists were compared to the rooms with "Contact Precaution" signs on the door and ten rooms were missing the signs.

In addition, two additional residents in identified rooms were identified by inspector #571 to be colonized with ARO when lab results were reviewed.

In separate interviews on February 18, 2016, PSW #120 indicated one of the residents had an ARO infection but she did not know which one and only wears gloves during direct care. PSW #111 provided direct care to the resident in an identified room wearing only gloves. When asked if she was supposed to wear a gown during care, she stated "I don't know that". PSW #109 indicated that neither of the two residents in another identified room was on contact precautions despite the "Contact Precaution" sign on the door being brought to his/her attention by inspector #571. PSW #120 and #111 indicated that isolation gowns are stored in a room located in the west hallway.

In an interview on February 22, 2016, PSW #108 indicated that he/she wears gloves when providing direct care to the resident in an identified room but would get an isolation gown if changing a "messy" bowel movement. A contact precaution sign on the door indicated gloves and gowns should be worn when staff are providing care.

In an interview on February 23, 2016, PSW # 106 indicated that the residents in an identified room were not under contact precautions. When Inspector #571 brought the "Contact Precaution" sign to his/her attention, PSW #106 indicated the sign must be new and asked RPN #101 for confirmation. RPN #101 indicated that the contact precautions for that room was not new but was unable to indicate which resident was under precautions and would have to look

in the clinical health records. RPN #101 indicated that PSW's would know which resident was under precautions by looking at the resident's kardex.

The kardex for resident #059 who resides in that room indicated:
- Follow Additional Precautions/Contact Precautions as per signage on door
- Resident is in a semi-private room; Ensure hygiene and toileting products are in a dedicated area.

In an interview on March 2, 2016, RPN #131 indicated that one resident was on contact precautions for an identified condition. Inspector #571 inquired why a contact precaution sign was not on the resident's door; RPN #131 explained that sometimes residents remove the signage.

In an interview on March 2, 2016 on PSW #100 indicated there were currently no residents on the unit on contact precaution and that when residents are on contact precaution, there is the contact precaution signage on the door and sometimes a yellow bag containing PPE.

In an interview on March 2, 2016, RPN #133 indicated that the residents in identified rooms are on contact precautions and showed the inspector the report sheet that indicated this information. RPN #133 informs the PSW's during report of any residents who are on contact precautions.

The DOC indicated in an interview on March 1, 2015, that she has been working closely with Public Health Officer (PHO) #132 over the past two years to reduce the number of residents diagnosed with an identified infection. The DOC indicated that PHO #132 informed the DOC that gowns only have to be worn if staff were going to be in direct contact with the source of the infection/colonization. The DOC indicated that when staff change an incontinent product, they were not at risk for coming into direct contact with the source of the infection/colonization. The DOC and ADOC are on the infection control team and they decide if staff are going to be at risk for direct contact with the source of infection/colonization. If they determine that isolation gowns are necessary, then either the DOC or the ADOC hang a yellow isolation bag on the door that contains isolation gowns in addition to a "Contact Precaution" sign. Therefore, if a yellow bag is absent from the door and a "Contact Precaution" sign is present, staff only need to wear gloves during direct care.

In a telephone interview on March 1, 2016, PHO #132 indicated that a couple

years ago she had provided recommendations regarding surveillance and infection prevention and control measures that should be in-place at the LTCH to prevent transmission of infection to other residents and staff. She indicated that the LTCH was advised gowns and gloves should be worn when providing direct care (including bathing and incontinence care), to a resident who is infected or colonized with an identified organism..

A review of the licensee's policy IPC-B-20 entitled Additional Precautions – Contact Precaution revised August 2015 indicates that gloves and gowns should be worn for direct care/contact including bathing, washing and continence care and any necessary personal protective equipment is to be available at point of care.

Therefore, the licensee failed to ensure that all staff participate in the implementation of the homes Infection Prevention and Control program by failing to ensure that: all staff wore appropriate personal protective equipment when providing direct care to a resident under contact precautions; that gowns were available at point of care; all residents with ARO's were tracked and that signage alerting staff and visitors to use contact precautions were in place for all residents identified with ARO.

The home's compliance history was reviewed and the following supports the ongoing non compliance identified:
- April 2015 - the home received a WN and VPC related to staff not complying with the hand hygiene program.
- May 2014 - the home received a WN related to immunization and screening for new admissions.
As a result of reviewing the scope, severity and compliance history, a compliance order is warranted.

(571)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 17, 2016

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
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
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 Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
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
Inspection de sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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
Inspection de sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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 23rd day of March, 2016

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Maria Francis-Allen

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