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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 28, 2016	2016_286547_0010	008233-16	Resident Quality Inspection

Licensee/Titulaire de permis

CENTRE D'ACCUEIL ROGER SEGUIN
435 Lemay Street Clarence Creek ON K0A 1N0

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

CENTRE D'ACCUEIL ROGER SEGUIN
435 Lemay Street Clarence Creek ON K0A 1N0

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

LISA KLUKE (547), LINDA HARKINS (126), MELANIE SARRAZIN (592)

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): April 4, 5, 6, 7, 8, 11, 12, 13, 14, 2016

The following critical incident inspections were conducted during this resident quality inspection:
log's #005932-15 and #004660-16 related to falls resulting in transfer to hospital with significant change in condition.

During the course of the inspection, the inspector(s) spoke with residents, families, President of Resident's Council, Registered and non-Registered nursing staff, Dietary aides, Maintenance staff Supervisor, maintenance staff, housekeeping staff, restorative staff, Registered Dietitian, Director of Care (DOC) and the Administrator.

In addition the inspection team, reviewed resident health care records, food production documents including planned menus, resident dietary reports, resident council minutes, family council documents, Fiche Signaletique documents, policy and procedures related to: resident weight management, enregistrement de la consommation alimentaire des solides et des liquides, physical restraints, infection, prevention and control. The inspection team observed aspects of resident care and interactions with staff, along with medication administration and several meal services.

The following Inspection Protocols were used during this inspection:

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
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

8 WN(s)
4 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

In accordance with O Reg 68 (2) (d), the home shall have a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration.

The home policy titled “Enregistrement de la consommation alimentaire des solides et des liquides” SD-NUT 2519 , dated August 2005 and last reviewed November 2014 indicated the following:

"goal: To meet the Ministry of Health requirements by compiling, most accurate as possible, the alimentary consumption of solids and liquids of residents to evaluate if the alimentary consumption is appropriate and respond to resident’s needs".

"Procedure: Staff will receive the necessary training to collect the consumption for solids and liquids and to document to the appropriate place".

The home has a system in place to monitor and evaluate the food and fluid intake of residents called the Dietary Report flow sheet. The Dietary Report flow sheets are utilized for documentation for both food and fluids for residents and is to be maintained for each meal and snack service.

Resident #015 was admitted to the home in 2001 with several health diagnoses.

Upon a review of the resident's health care record, it indicated that between August 2015 and March 2016, resident #015 had lost a specified amount of kilograms(kg).

Upon a review of the Dietary Report flow sheets for 31 days between March and April 2016, it was noted that resident #015's intake for breakfast was recorded only eight times, intake for lunch was recorded only nine times and intake for dinner was recorded only seven times.

In an interview with Dietary Aid #111, she told Inspector #592 that she was the staff responsible to obtain and record the intake for residents in a specified dining room on the Dietary Report flow sheets. Dietary Aid #111 confirmed that resident #015 eats in the specified unit's dining room and was part of her assignment. She further told Inspector #592 that only the residents identified as being at high risk for nutritional needs were recorded on the Dietary flow sheets and the other residents who were not considered at high risk were recorded only if they had time to do so.

In an interview with the home's Dietitian, she told Inspector #592 that resident #015 was recently diagnosed with a new healthy care issue. She further stated that only the residents identified at high risk for nutritional needs were to be recorded on the Dietary Report flow sheet due to the lack of time in the dining room. The Dietitian told Inspector #592 that residents identified at high risk, were residents with weight loss/monitoring, risk of choking or with several food restrictions. The Dietitian further indicated that staff should verbalize if there were any problems with non-high risk residents and that this method was temporally in place to focus on the high risk residents rather than going randomly to choose any resident to record due to lack of time. The home's policy # SD-NUT 2519 does not identify between high and low risk residents with respect to intake monitoring.

Following the discussion with the Dietitian, the Dietary Report flow sheets were reviewed for residents identified on the home's dietary memory aide in the specified unit Dining Room as high risk. Residents #044, #032 and #057 are identified on this list as high risk for nutritional needs.

Resident #044's Dietary Report for a 32 day period from specified dates from March to April 2016, indicated that the intake for breakfast was not recorded four times, the intake for the morning snack service was not recorded three times, the intake for lunch was not recorded once, the intake for the afternoon snack service was not recorded three times, the intake for dinner was not recorded 25 times and the intake for the evening snack service was not recorded five times.

Resident #032's Dietary Report for a 32 day period from specified dates from March to April 2016, indicated that the intake for breakfast was not recorded 21 times, the intake for the morning snack service was not recorded four times, the intake for lunch was not recorded three times, the intake for the afternoon snack service was not recorded eight times, the intake for dinner was not recorded 24 times and the intake for the evening snack service was not recorded twice.

Resident #057 Dietary Report for a 32 day period from specified dates from March to April 2016, indicated that the intake for breakfast was not recorded nine times, the intake for morning snack service was not recorded eight times, the intake for lunch was not recorded five times, the intake for afternoon snack service was not recorded 10 times, the intake for dinner was not recorded 26 times and the intake for the evening snack service was not recorded five times.

On April 13, 2016, in an interview with the Dietitian, she told Inspector #592 that she was not aware that residents identified at high risk for nutritional needs were not recorded on the Dietary Report at each meal and snack service and confirmed that the home was not in compliance with their written policy with respect to recording all food and fluids for all residents in the home. [s. 8. (1) (a),s. 8. (1) (b)]

2. In accordance with O Reg 68 (2) (a), the nutrition care and Hydration program shall include the development and implementation of policies and procedures related to nutrition care and dietary service and hydration. The nutrition care program is to include a weight monitoring system.

The home policy titled “Prise de la taille et du poids du resident” # SD-NUT 2501 dated March 2008 and last reviewed November 2014 indicated that :

"The dietitian and/or the Food Service Supervisor will evaluate each month, the weight of each resident to take necessary steps if needed".

Procedure indicated:
"The nurse in charge will record each month the resident weight. If a difference of more than 2kg, the resident must be re-weighed to ensure that the weight is accurate.
The nurse will ask for a dietitian consultation indicating a significant change in the resident weight if the difference of 2kg is maintained".

Resident #012 was admitted on a specified date in 2015 with several health diagnoses.

In a review of the resident's health care record it was indicated that resident #012’s weight had declined during a three month period in 2016.

-On a specified date in January 2016, resident’s weight was recorded.

-On a specified date in March 2016, resident's weight was recorded as having lost 4.6 kg since the January 2016 weight.

Resident #044 was admitted in 2015 with several health diagnoses.

In a review of the resident's health care record it was indicated that resident #044's weight had declined over a two month period between in 2016.

-On a specified date in January 2016 resident #044's weight was recorded.

-On a specified date in February 2016 this resident's weight was recorded as having lost 7.6kg.

On April 12, 2016, in an interview with PSW #115, she indicated to Inspector #592 that staff take each resident weight monthly and record the weight on a paper assigned on each unit for the nurse to look at it.

In an interview with RN #113 she showed Inspector #592 the tracking sheet for the weight monitoring system and indicated that the weights were to be taken monthly and recorded by the PSW on the tracking sheet called "poids mensuel". She further told Inspector #592 that if a recorded weight makes no sense by being approximately higher or lower than 10kg, that she would instruct the PSW staff to re-weigh the resident. RN #113 further told Inspector #592 that there was no specification of when to refer a resident who has a decline in weight to the dietitian as the dietitian has her own tracking system. She further told Inspector #592 that resident #012 recorded weight loss from February to March 2016 was not a significant weight loss for the resident, and therefore there was no need to inform the dietitian.

In an interview with RN #108, she told Inspector #592 that the dietitian was the person responsible to monitor the resident weights. She further told Inspector #592 that resident #044's weight loss was not flagged to the dietitian as it was the dietitian's role to track the resident weights in the system and that she would request the staff to re-weigh residents.

On April 12, 2016, in an interview with the home's Dietitian, she told Inspector #592 that resident #012 was admitted with a weight above the normal range. The Dietitian further told Inspector #592 that she was not made aware of the significant change for both residents, therefore no assessments or interventions were done. She further told Inspector #592 that the last evaluation for resident #012 and #044 were completed in

January 2016 and that she should have been notified by the Nursing staff for resident #012 who had declined in weight. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home complied with their written policy regarding the documentation procedures relating to nutrition care and dietary services and hydration for monitoring of resident food and fluid consumption and monitoring of resident weight changes, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents.

Centre D'Accueil Roger Seguin is a two level home with a total of four units.

On April 4, 2016, Inspector #592 observed two soiled utility rooms not equipped with any locks and found to be accessible to residents with no staff supervision.

One of the soiled utility rooms located on the second floor contained, luxury foam hand soap in plastic containers in a cupboard, garbage containers, lift battery chargers and three white laundry bags tagged "soiled".

The other soiled utility room located on the main floor contained: one gallon of Wash'n Walk no-rinse floor cleaner, one gallon of Cleaner, Disinfectant and Deodorizer and one gallon of detergent located on the floor, all connected to a central dispenser.

As per the product Material Safety Data Sheet provided by the home, one of the three products, Wash'n Walk no-rinse floor cleaner, is classified under the Workplace Hazardous Materials Information System (WHMIS) classification as a Class D2A and D2B product. D2A is defined as very toxic material and D2B defined as toxic.

In an interview on April 7, 2016, with the Administrator, he told Inspector #592 that both soiled utility rooms were not residential areas. At the time of the interview, the Administrator spoke with the Maintenance staff Supervisor who told Inspector #592 that these doors were not equipped with locks. The administrator told Inspector #592, that a lock would be installed on both soiled utility doors as soon as possible. [s. 9. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to non-residential areas , such as the soiled utility rooms, must be equipped with locks to restrict unsupervised access to those areas by residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents.

For the purpose of this report, the communication and response system is referred to as a call bell system.

The home has a total of three dining rooms.

On April 4, 2016 Inspector #592 observed the first floor dementia unit and the second floor dining rooms, were not equipped with a communication and response system accessible by residents.

During an interview with Restorative Aide #100 and PSW #103 indicated to Inspector #592 that there is no call bell system in both dining rooms and if they required assistance for any emergency, they would leave the dining room and get the Registered Nursing

staff member at the nurses station.

During an interview with the Administrator, he indicated to Inspector #592 that he was not aware that both dining rooms were not equipped with a communication and response system. [s. 17. (1) (e)]

2. Inspector #547 noted on April 11, 2016 that the four sitting areas called "salons" on each home unit were not equipped with any communication and response system.

On April 6, 2016 Inspector #547 interviewed a resident seated in a rocking chair on the first floor east sitting area and no staff member was with the resident as he/she was sitting alone.

Inspector #547 interviewed the Administrator on April 12, 2016 regarding no resident-staff communication and response systems in these sitting areas, and confirmed that there were no call systems installed in the "Salons". The Administrator indicated that these sitting rooms are to be used by residents in the home and they recently purchased new rocking chairs for resident comfort. The second floor west sitting area was noted to have a stepper exercise machine facing the window used by residents, and resident staff communication system is in place in this area. The Administrator indicated that he was not aware that these areas did not have any call bell systems installed for residents. [s. 17. (1) (e)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all dining rooms and living room areas accessible by residents are equipped with a resident-staff communication and response system, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

s. 31. (3) If a resident is being restrained by a physical device under subsection (1), the licensee shall ensure that,
(b) the resident is monitored while restrained, in accordance with the requirements provided for in the regulations; 2007, c. 8, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the restraining of resident #016 by physical device(table top) was included in the plan of care, that the restraint plan of care include an order by the physician for the table top and the bed rails, that the restraint plan of care include consent by the Substitute Decision Maker (SDM) and that when a resident is being restrained by a physical device under subsection (1), the licensee shall ensure that, (b) the resident is monitored while restrained, in accordance with the requirements provided for in the regulations; 2007, c. 8, s. 31 (3).

Resident # 016 was admitted to the home on a specified date in 2013 with several health diagnoses.

On a specified date in April 2015 resident #016 was observed to be sitting up in a wheelchair with a front tying seat belt and a table top. Resident #016 was unable to undo the seat belt or push off the table top. Resident #016 was observed again three days later in the afternoon to be sleeping in bed with two full bed rails in the up position.

Resident #016 health care records was reviewed by Inspector #126 and no documentation was found related to a physician order for the application of the table top and for the utilization of full bed rails when the resident was in bed. The table top was noted to not be included in the plan of care. There was no documentation related to obtaining the consent of the SDM for the application of the table top or the utilization of the bed rails.

Personal Support Workers (PSW's) and Registered Nursing Staff on the second floor indicated to Inspector #126 that the monitoring of the utilization of restraints was done on an hourly basis and that the monitoring was to be documented in the “Restraint Binder”. The “Restraint Binder” was reviewed and it was noted that the monitoring and documentation of the application of the seat belt was completed for resident #016 but did not include the monitoring and documentation of the application of the table top or the application of the two bed rails. RN #113 identified that resident #016's table top and bed rails as restraints that should be documented in the "Restraint Binder".

The DOC indicated to Inspector # 126 during an interview that recently they had reviewed all resident restraints in the home and that resident #016’s restraint information should have been up to date as he/she had been in the home for a while. [s. 31. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident #016 is being restrained by physical devices that are included in the resident's plan of care and that all requirements related to these restraints has been followed, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On April 11, 2016 at approximately 1210 hours, Inspector #126 observed that PSW #114 started to serve the dessert course to residents that had not finished their main course.

Resident #045 and #046 were served the dessert course while they had not finished their main course. Resident # 047 was observed to be eating the main course and when served the dessert, he/she pushed away the main course and started to eat the dessert.

Dietary Aid #118 indicated to Inspector #126 that they start to serve the dessert course to the first table even if they have not finished their main courses. The Registered Dietitian indicated that residents shall be served course by course and that at this time in the home, no resident were identified as requiring having the dessert served with their main course.

Resident #045, #046 and #047's plan of care were reviewed by Inspector #126 and no documentation related to the needs of those residents to be served all meal courses at the same time. [s. 73. (1) 8.]

WN #6: 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 the Director is informed no later than three business days after an incident has occurred that caused an injury to a resident for which the resident is taken to a hospital. When 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 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 inform the Director of this incident no later than three business days after the occurrence of the incident.

On a specified date in January 2016, resident # 041 was found on the floor in the bathroom. Resident #041 was yelling and complaining of pain when mobilized and the resident's blood pressure was high. Resident #041 was sent to the hospital for an assessment. Resident #041 returned to the home five days later with a fracture of specified area.

Inspector #126 interviewed the Director of Care who indicated that the Director was notified seven days after the resident was sent to hospital, not within the required time specified by this section. [s. 107. (3.1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 219. Retraining

Specifically failed to comply with the following:

s. 219. (4) The licensee shall ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes,
(a) hand hygiene; O. Reg. 79/10, s. 219 (4).
(b) modes of infection transmission; O. Reg. 79/10, s. 219 (4).
(c) cleaning and disinfection practices; and O. Reg. 79/10, s. 219 (4).
(d) use of personal protective equipment. O. Reg. 79/10, s. 219 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76(2) and subsection 76(4) of the Act includes cleaning and disinfection practices.

On April 28, 2016 Inspector #547 interviewed the home's DOC regarding the retraining material provided to staff annually for infection prevention and control practices. The DOC indicated that she is the lead for the infection prevention and control program in the home and that the home follows the Provincial Infectious Disease Advisory Committees (PIDAC) as best practices. She further indicated that she did not retrain staff on the requirement for cleaning and disinfection practices in the home as part of the infection prevention and control training provided to nursing staff last Fall 2015. The DOC is aware that this was a missing item of review in the re-training program for last year.

The DOC further indicated that the use of shared nail clippers identified in the non-compliance for s.229(4) in this report, possibly could have been prevented as the home's practice is that every resident is to have their own nail clippers, labelled with their name, and to be used only for themselves. The DOC realized that if the training had been provided to staff as a refresher annually as required, the nursing staff would have realized that the use of the tub cleaning solution is not an acceptable method according to PIDAC best practices to sterilize nail clippers between residents, and re-enforced that the home's practice is to not share nail clippers or other personal use items. [s. 219. (4) (c)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program regarding the use of shared nail clippers.

Inspector #592 observed unlabelled nail clippers in the bottom of tubs in two separate specified tub rooms on April 4, 2016.

Inspector #547 observed unlabelled nail clippers in one of the same specified tub rooms identified on April 4, 2016 in the bottom of the tub three days later. This tub was noted to be clean and dry. The unlabelled nail clippers did not have any nail debris and was wet. Another pair of unlabelled nail clippers was noted on the top of the tub, open also without nail debris and wet to touch. The other tub room identified on April 4, 2016 was also observed and noted unlabelled nail clippers inside the cupboard next to this tub.

Inspector #547 interviewed PSW #119 as working on the floor where both these tub rooms were located and indicated that all residents have their own nail clippers labelled with their name and they bring their items to the bath on their bath day. The home also has spare unlabelled nail clippers in the tub rooms, as a few residents do not have their own nail clippers. PSW #119 further indicated that once a bath is complete, the PSW’s wash any common use items like combs and nail clippers with the tub cleaning solution and dry them and return them to the basket for another resident. Inspector #547 noted that the tub/shower cleaning solution is not a high level disinfectant solution.

Inspector #547 interviewed PSW #106 on another floor in the home, indicated that all residents in the home have their own nail clippers with their name on them and that the home does not keep any spare nail clippers in the tub rooms. If a resident is missing a nail clipper, the PSW’s are expected to go to the nursing station and get a new pair and place the resident's name on them.Inspector #547 interviewed Charge RN #108 for this

same floor regarding the home's expectations for cutting resident nails, and the purpose of the spare nail clippers unlabelled in the tub rooms. Charge RN #108 indicated that no spare nail clippers are to be kept in the tub rooms, as if any resident needs nail clippers, each floor keeps a stock of new nail clippers that are to be labelled for the residents to keep in their personal bins in their room. Charge RN #108 indicated that there is no process to clean unlabelled nail clippers with the tub cleaning solution, as no nail clippers are to be shared.

Inspector #547 interviewed Charge RN #113 for the specified floor where unlabelled nail clippers were located in tub rooms, regarding the home's expectation for nail clippers for residents and she indicated that every resident has their own nail clippers with their name on it. Charge RN #113 indicated that some residents do not keep their nail clippers in their rooms for safety, but the nail clippers should still be labelled and kept in the tub rooms for those residents. No unlabelled nail clippers should be used or cleaned between residents as nail clippers are not to be shared.

In an Interview with the DOC regarding the use of non-labelled common use nail clippers on the specified floor of the home and she indicated that the home does not have a policy and procedure for cleaning and disinfecting resident nail clippers, however the home's expectation according to the Provincial Infectious Disease Advisory Committees (PIDAC) as best practices, is that every resident has a labelled nail clipper to be used for themselves and no common use nail clippers are to be used in the home.

Measures are not in place for the cleaning, disinfection or sterilization of re-usable and/or shared resident equipment which poses a potential cross- contamination infection risk to residents. [s. 229. (4)]

Issued on this 18th day of May, 2016

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

Original report signed by the inspector.