Ontario

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

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Inspection de soins 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
May 31, 2016	2016_346133_0020	008568-16	Complaint

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE LAURIER MANOR
1715 MONTREAL ROAD GLOUCESTER ON K1J 6N4

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

JESSICA LAPENSEE (133)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): May 12th, 13th and 27th, 2016.

This complaint inspection was related to a complaint regarding pest control.

During the course of the inspection, the inspector(s) spoke with the acting Administrator, the Director of Care, the Support Services Manager, registered and non registered nursing staff, a housekeeper, a resident and a resident's visitor.

The Inspector reviewed documentation related to the pest control program and observed insect monitoring devices in some areas on the second floor.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 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. 88. Pest control

Specifically failed to comply with the following:

s. 88. (1) As part of organized programs of housekeeping and maintenance services under clauses 15 (1) (a) and (c) of the Act, every licensee of a long-term care home shall ensure that an organized preventive pest control program using the services of a licensed pest controller is in place at the home, including records indicating the dates of visits and actions taken. O. Reg. 79/10, s. 88 (1).

s. 88. (2) The licensee shall ensure that immediate action is taken to deal with pests. O. Reg. 79/10, s. 88 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 88 (1) in that the licensee has failed to ensure that the organized preventive pest control program in place includes records indicating actions taken.

The licensee has a history of non-compliance in this area. As a result of complaint inspection #2016_346133_0011, conducted on March 1st and 3rd 2016 by the Inspector, a written notification was issued with regards to the pest control program service records.

As had been previously established by the Inspector, (inspection #2016_346133_0011) the home's licensed pest controller is Orkin Canada. There were, at a minimum, monthly service visits. The Orkin service records were formally known as "service exception reports" (reports) and were produced by the pest control technician (PC technician) from a handheld device at the time of the service delivery using the "Smartscan" system.

On May 12th, 2016, the Inspector met briefly with the home's designated PC technician. Related to resident bedrooms, he explained to the Inspector that once the home's Support Services Manager identified a bedroom that was in need of treatment due to insect pest activity, he would return to that bedroom the next month and observe the glue board insect monitors in place to ascertain if further treatments were required. The Inspector had not been previously aware of this process, during inspection #2016_346133_0011.

The reports did not capture the PC technician's follow up inspection process for all bedrooms that were treated due to insect pest activity.

Following the discussion with the PC technician on May 12th 2016, the Inspector reviewed the monthly reports for 2016. It was noted that bedrooms were only subsequently referenced in reports if they had been treated again. For example, as per the March 3, 2016 report, there was observed insect pest activity, which resulted in treatment, in two third floor bedrooms and seven fifth floor bedrooms. The April 11, 2016 report (April report) referenced treating two of the fifth floor bedrooms identified in March and one fifth floor bedroom that was not identified in March. The April report did not reflect a follow up inspection in the other five fifth floor bedrooms that were treated in March. The April report referenced treating one third floor bedroom and did not reflect a follow up inspection in the two third floor bedrooms treated in March. The April report referenced treating two fourth floor bedrooms. The May 06, 2016 service report

referenced treating three bedrooms on the fifth floor, two of which were treated in April. The May report did not reflect follow up inspections in the other fifth floor bedroom that was treated in April. The May report did not reflect follow up inspections in the third and fourth floor bedrooms treated in April.

Further to the above, on May 12th and 13th, 2016, the Inspector noted that some previously identified concerns (inspection #2016_346133_0011) related to the pest control program service reports (reports) remained unchanged. The Inspector focused on the April 11th, 2016 and May 6th, 2016 service reports.

The reports did not reflect all actions taken, as documentation of actions taken was by exception.

In the service summary area of each report, the number of devices "serviced" was noted, the number of devices "serviced with detail recorded" was noted, the number of "missed" devices was noted, and the number of "total devices" was noted.

The PC technician previously explained to the Inspector (inspection #2016_346133_0011) that if he observed a device(s) in an area and there was no insect pest activity and he did not have to do anything to the device(s), this would be registered as a "serviced" device(s). If any action was taken, further to an observation, the device would be registered as "serviced with detail recorded". The PC technician indicated to the Inspector that it should be assumed that every device in the home was observed during every service visit, and that this included glue board insect monitors in each kitchenette.

Based on the information within the reports, there was no way to determine the location of pest monitoring devices throughout the home. There were no floor plans or other such supporting information available within the pest control binder. As well, there was no way to determine the location of devices that were observed where there was no detail recorded (i.e "serviced" vs "serviced with detail recorded"). With the information provided, an assumption could not be made as to where the PC technician had gone during the monthly service visits and what devices had been observed.

For example, on May 12th, 2016, with a focus on a report of an identified insect pest sighting within the second floor dining room, the Inspector observed four glue board insect monitoring devices, within the second floor kitchenette. The April and May reports did not provide information to the effect that the devices had been observed by the PC technician during those service visits. The devices were not dated to indicate when they

had been last observed by the PC technician.

The details of actions taken in the reports could not always be interpreted.

Where devices were "serviced with detail recorded", it was not always possible to ascertain location of actions take due to the use of alphanumeric codes and the use of location categories that did not always reflect actual locations. The reports, or the pest control binder, did not include a corresponding legend to allow for the interpretation of the codes and categories used.

As previously established (inspection #2016_346133_0011), the letter "M" represented an insect monitor (glue board). M2 was used as a code to represent the kitchenette on the fifth or third floor, it could also be used to represent a bedroom(s) on the floor, a nurses' station, or other common areas serviced by the PC technician on that floor. M3 was used as a code to represent such areas on the fourth or second floors. In the service detail section, the M2 and M3 codes were always used under the second "Interior" category and "Kitchen" subcategory. The PC technician had previously explained that a second "Interior" category was always related to the general pest control program, as opposed to the specific fly control program captured by the first "Interior" category, as was a second "kitchen" subcategory. The service reports did not include such explanatory detail to allow for interpretation.

For example, looking at the May 6th, 2016 service report, in reference to the use of the M2 code, the following is noted: INTERIOR – KITCHEN – M2.0 Serviced, insect activity, treated rooms A,B,C (three identified fifth floor rooms). Inclusion of bedroom numbers on the original service report allows for an assumption that this M2 code is related to actions taken on the fifth floor as opposed to on the third floor. It could not be determined if actions were taken exclusive to the referenced bedrooms, or if there were actions taken in other areas, such as the kitchenette.

On May 27th, 2016, the Inspector returned to the home to meet with the Support Services Manager (SSM), who had been away from the home on May 12th and 13th, 2016. The SSM was the home's primary contact for the PC technician and the manager with primary responsibility for the organized pest control program. The Inspector was informed that following May 13th, 2016, the PC technician was at the home, related to an identified type of insect pest, on May 16th, 19th. In addition, the PC technician was expected for a service visit on that day. The PC technician had not used the Smartscan system to generate the service reports for the two previous visits, not did he use the

system to generate the service report on May 27th, 2016. The reports were handwritten by the PC technician, and detailed actions taken during the visit. The SSM also provided the Inspector with a copy of his ongoing pest management activity document, which was initiated following the Inspector's previous inspection (#2016_346133_0011). [s. 88. (1)]

2. The licensee has failed to comply with O. Reg. 79/10, s. 88(2) in that the licensee failed to ensure that immediate action is taken to deal with pests.

This finding of non compliance is related to one identified type of insect pest.

On May 12th, 2016, the Inspector began a complaint inspection at the home. The compliant was related to an identified insect pest sighting, on a ledge next to table #16, in the second floor dining room, the week of March 14th 2016.

It had been previously established (inspection # 2016_346133_0011) that the home receives monthly service, at a minimum, from a licensed pest controller with Orkin Canada. The pest control program includes ongoing monitoring, and treatment as needed, of areas throughout the home due to ongoing activity of the identified insect pest.

On May 12th, 2016, the Inspector met briefly with the home's designated pest control technician (PC technician) to discuss the April 11th, 2016 and May 6th, 2016 service visits, with a focus on the second floor. The PC technician indicated that during those service visits, he would have observed the glue board insect monitoring devices within the second floor kitchenette. The PC technician explained that the devices had not revealed any activity of the identified insect pest within the kitchenette. The PC technician explained that no information had been provided to him that would necessitate any additional pest control actions, in any other areas on the second floor. The PC technician indicated that at some point in the past, a glue board insect monitoring device had been placed in the far corner of the dining room, in the area of the fireplace. The PC technician explained that after checking it a few times, it had been removed, as there had been no insect pest activity.

On May 12th, 2016, between 1130 hours and 1250 hours, the Inspector spoke with nursing staff, and a resident's visitor, in the second floor dining room. The Inspector inquired if they had observed the identified insect pest in the area.

A Personal Support Worker (PSW), #S101, told the Inspector that she had seen the

identified insect pest in the dining room, in the area of the fish tank, about two weeks ago. The PSW explained that she had not reported the sighting, because it was a known issue and there was a pest control program in place.

A Registered Practical Nurse (RPN), #S102, told the Inspector that she had seen the identified insect pest in the RAI coding room, close to the dining room. The Inspector accompanied the RPN to the room and met another PSW, #S103. The RPN and PSW told the Inspector that, for example, they had seen one in the water reservoir of the coffee machine. The RPN and the PSW indicated that they had reported their sightings to the Support Services Manager (SSM). PSW #S103 explained that his most recent sighting was on May 6th, 2016. He elaborated that he had seen a one on the wall behind the computer monitor that morning. The PSW indicated that he had not reported this sighting to the SSM. Following this conversation, the Inspector located a glue board insect monitoring device in the back left corner of the room. The monitor was dirty with accumulated dust and debris, and was not dated. The Inspector observed that there were 12 of the identified insect pests on the monitor.

A resident's visitor told the inspector that about three months ago, she had seen one of the identified insect pests in the corner of the ledge at table #17, which is next to table #16. The visitor explained she had seen them in the area two or three times before that. The visitor indicated that she had informed staff in the area about the sighting, and that she believed that all staff knew this was a problem.

An RPN, #S104, told the Inspector that she had also seen the identified insect pest on the ledge next to tables #16 and #17, as recently as last week. The RPN explained that there were glue board insect monitoring devices in use in resident bedrooms, and that management was aware of the identified insect pest issue. The RPN did not feel that there was a need to report the ongoing sightings of the identified insect pest.

At approximately 1500 hours, on May 12th, 2016, the Inspector spoke with a PSW, #S105, and an RPN, #S106, in the second floor RAI coding room. The PSW, #S105, indicated that she had seen the identified insect pests in the second floor dining room, along the ledge next to table #16 and #17, and in the area of the fish tank. She qualified that the most recent sighting, related to the dining room, was in the area of the fish tank. This was about a month and a half ago, and had been reported to the SSM. PSW #S105 explained that she had pulled out a piece of paper from underneath the fish tank, and there had been some of them on it. Related to the ledge sighting, it was one of them, and it was a couple of months ago. The identified insect pest had been underneath

something she picked up. PSW #S105 indicated she had also seen one of them in the back corner of the dining room, in the area of the television, a few months ago. PSW #S105 informed that the week before, she had seen one of the identified pests in the top drawer of a resident's bedside table in an identified bedroom. PSW #S105 informed that she had seen several of them in another identified resident's bedroom, on the floor, when she had moved the resident's bedside table. PSW #S105 indicated that with the exception of the fish tank, she had not reported these sightings. The RPN, #S106, indicated that he had most recently seen one of the identified insect pests in the second floor staff bathroom, on the inside of the door. This sighting occurred the week before, and had not been reported. The staff bathroom is across the hallway from the dining room. The RPN indicated that he hadn't seen any of the identified insect pests recently in the dining room. The PSW and RPN both explained that they do not report all sightings because management is aware of the ongoing issue.

On May 13th, 2016, the Inspector spoke with a housekeeper, #S107, in one of the second floor bedrooms identified by PSW #S105 the previous day. The housekeeper indicated that she often sees the identified insect pests in the dining room, in the area of the fish tank. She indicated that she had reported this to the SSM as recently as last week. The housekeeper also reported seeing one of them in the second floor staff bathroom, on the floor next to the garbage can, the day before. This sighting had not been reported. The housekeeper indicated she had not seen any of them in resident bedrooms on the second floor.

On May 13th, 2016, following conversation with the housekeeper, the Inspector went into the other bedroom identified by PSW #S105 the previous day. Within the area of bed #2, the Inspector observed that there was an open glue board insect monitor stuck to the bottom of the back right leg of the resident's television stand. The monitor was not dated. There was one of the identified insect pests on the monitor.

On May 13th, 2016, the Director of Care (DOC) explained to the Inspector that when staff see the identified insect pest, they are expected to try and kill it/them, and to immediately report the sighting to their supervisor to allow for follow up action. The Support Services Manager (SSM) is to be made aware of all sightings, so the licensed pest controller can be informed and implement a monitoring program for the area and treat accordingly. The SSM was not present on May 12th and 13th, 2016. The Inspector was told that the SSM would be returning on May 24th, 2016. The Inspector shared all reports of sightings of the identified inspect pest with members of the management team on May 13th, including the acting Administrator and the Director of Care. The acting Administrator advised the

Inspector that the PC technician would be called in for service.

On May 27th, 2016, the Inspector returned to the home to meet with the SSM. Related to the second floor RAI room, the SSM explained that he had placed a glue board insect monitoring device in the back corner of the room, and had asked staff to let him know if there was any activity. The SSM indicated he had not heard anything further about the RAI room after placing the monitor. Related to second floor staff bathroom, the SSM indicated he had not been made aware of any sightings of the identified insect pest there. Related to the area within the dining room around the fish tank, the SSM indicated that he had been made aware of the sightings of the identified insect pest. He explained that he and the former Administrator had been discussing potential solutions, such as filling in the space beneath the tank. The SSM had not been aware of the other sightings of the identified insect pest that had been communicated to the Inspector on May 12th and 13th, 2016. The SSM informed that on May 16th, 2016, Pest Control Activity Log books were put into use on all units, and that all staff had been made aware of the need to document any observed pest activity. The SSM informed that there would now be weekly service visits from the licensed pest controller, which would include review of all documented sightings.

On May 27th, 2016, at approximately 1200 hrs, the Inspector went into the second floor staff bathroom. The Inspector observed one of the identified insect pests, on the floor, going along the side of the wall opposite the door, after the radiator. The identified insect pest went into a hole between baseboards, in the corner, beneath the sink. The Inspector observed a glue board insect monitor within the pipes underneath the sink. The Inspector observed that there were none of the identified insect pests on the monitor. The inspector reported the sighting to the SSM and documented it in the pest control activity log book. [s. 88. (2)]

Issued on this 1st day of June, 2016

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

Original report signed by the inspector.