Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Aug 22, 29, Sep 11, 12, 2012	2012_072120_0064	Other

Licensee/Titulaire de permis

RYKKA CARE CENTRES LP
50 SAMOR ROAD, SUITE 205, TORONTO, ON, M6A-1J6

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

EATONVILLE CARE CENTRE
420 THE EAST MALL, ETOBICOKE, ON, M9B-3Z9

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct an Other inspection.

During the course of the inspection, the inspector(s) spoke with the administrator, director of care and environmental services supervisor. (T-001563-12)

During the course of the inspection, the inspector(s) measured the light levels in resident washrooms and corridors, toured the laundry room, resident rooms, tub, shower, soiled and clean utility rooms, reviewed infection prevention and control policies and procedures and a bed safety audit report.

The following inspection Protocols were used during this inspection:

Infection Prevention and Control

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 18. Every licensee of a long-term care home shall ensure that the lighting requirements set out in the Table to this section are maintained. O. Reg. 79/10, s. 18.TABLEHomes to which the 2009 design manual appliesLocation - LuxEnclosed Stairways - Minimum levels of 322.92 lux continuous consistent lighting throughoutAll corridors - Minimum levels of 322.92 lux continuous consistent lighting throughoutIn all other areas of the home, including resident bedrooms and vestibules, washrooms, and tub and shower rooms. - Minimum levels of 322.92 luxAll other homesLocation - LuxStairways - Minimum levels of 322.92 lux continuous consistent lighting throughoutAll corridors - Minimum levels of 215.28 lux continuous consistent lighting throughoutIn all other areas of the home - Minimum levels of 215.84 luxEach drug cabinet - Minimum levels of 1,076.39 luxAt the bed of each resident when the bed is at the reading position - Minimum levels of 376.73 luxO. Reg. 79/10, r. 18, Table.

Findings/Faits saillants :

The licensee of a long-term care home has not ensured that the lighting requirements set out in the Table to this section are maintained.

The first floor corridor is lit with individual pot lights that do not emit adequate levels of continuous illumination. The levels were measured with a light meter to be 125 lux between pot lights. The levels under the lights were above 220 lux.

The 2nd, 3rd, and 4th floors have deeply recessed (12 inch deep) florescent tube lights spanning the width of the corridors, placed approximately 10 feet apart. The lux under these lights ranged between 400-500 lux, however as the meter moved away from the light, the level decreases to 100 lux when standing at the five foot mark. The lux level is therefore not a continuous 215.28 as required. The fifth floor has 6 inch deep recessed florescent tube lighting and was identified to be adequately illuminated.

General resident washroom lighting was measured to be 50 lux over the toilet area and 100 lux over the sink area. Some washrooms, such as in #208, the lux over the the sink was 50 and the lux over the toilet was 30. The required level is 215.48 lux.

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 lighting requirements set out in the Table to this section are maintained, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following subsections:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

[O. Reg. 79/10 s. 15(1)(b)] The licensee has not ensured that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

The management of the home conducted a bed safety audit August 26-30, 2011 to determine whether the beds posed entrapment risks to the residents. Seven zones of entrapment were tested for the 247 beds in the home and a minimum of 62 beds failed zones 1, 2, 6 & 7. According to the administrator of the home, the interventions to mitigate these risks included the provision of bolsters for gaps between the mattress and foot board, wrap around pads for the bed rails, some new mattresses and the discontinued use of bed rails. Changes have taken place with respect to resident bed rail use since the last audit and no information could be provided to determine the current status of the various bed entrapment zones.

During the inspection, numerous resident beds were observed to be missing bolsters for the large gaps in zone 7, which is the space between the end of the mattress and the foot board. The home's audit conducted in August 2011 identified the need for these beds to have bolsters, however no bolsters were provided.

Bed rails in various identified resident rooms were observed to be either both down or one side up. These rails were identified to have failed zone 1 for overly large rail openings within the rail. The home's intervention to address the entrapment risk was to add a wrap around pad over the rail. None of these rails had any padding on them.

A resident was observed to be lying on a mattress on an Echo bed frame in an identified room. The frame did not have mattress keepers installed in each corner of the frame to prevent the mattress from shifting. The mattress was off the frame of the bed by 3-4 inches. The addition of mattress keepers is another risk reducing measure for bed safety and is typically a requirement of the manufacturer during bed assembly.

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 where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment, to be implemented voluntarily.

WN #3: 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 subsections:

s. 229. (2) The licensee shall ensure,
(a) that there is an interdisciplinary team approach in the co-ordination and implementation of the program;
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly;
(c) that the local medical officer of health is invited to the meetings;
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

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. [O. Reg. 79/10, s.229(2)(d)] The licensee has not ensured that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The home's infection prevention and control program, which includes policies, procedures and practices, is evaluated annually, however the program has not been evaluated to determine if it is in accordance with best practices.

During the tour of the home and laundry area, observations were made that soiled linen is separated from general soiled linen when a person has been placed on "additional precautions". Residents who are on additional precautions are given a separate laundry hamper for their soiled linens and laundry staff acknowledged that they only wear gloves and gowns when handling "isolation" linen.

The home has several different policies and procedures relating to laundry processing and handling and they are contradictory. Some are found in the NOVA Laundry Manual and others in the Outbreak Control manual. Nova policy C-10-25 states that isolation linen processing is the same as regular linen processing and then states in policy C-10-15 that "contaminated linen is processed separately and a wash formula designated for use with infectious linen is to be used". In the home's outbreak control manual, policy IFC G-55, revised on July 11, 2008 states that "if a resident is in isolation, laundry will come down in a separate bag and handled by laundry staff as per precautions outlined in C-10. Masks and gowns will be used as defined under the precautions for the specific organism isolated".

"Best Practices for Environmental Cleaning for Prevention and Control of Infections, 2009" and "Routine Practices and Additional Precautions in All Health Care Settings, 2011" both state that "routine laundering practices are adequate for laundering all linens, regardless of source; special handling of linen for residents on Additional Precautions is not required". No distinctions are made between "contaminated" laundry from an ill person from those who are not ill in the best practices documents. Best practices identifies all laundry as contaminated and the method of handling and processing is the same for all soiled laundry. Best practices for laundry staff with respect to sorting or handling soiled linen is that staff have access to personal protective equipment such as gloves and a protective gown at all times.

2. [O. Reg. 79/10, s.229(4)] The licensee has not ensured that all staff participate in the implementation of the program.

The home has established procedures on the cleaning and disinfection of personal care articles and communal equipment. During the tour of the home, observations were made that staff do not follow the procedures.

(a) Shower chairs are not disinfected using "Virox" between each resident use as required by a policy titled "Equipment Cleaning/Disinfecting/Testing Schedule and Responsibilities". All shower rooms, from the 2nd floor to the 5th floor were inspected and only 2 rooms contained a disinfectant product. Shower rooms had a wall mounted holder for the disinfectant wipes container and the containers were observed to be empty or had several dried out wipes. The Virox wipes located in all but one tub room were either empty or expired. Personal support workers witnessed on the 2nd and 4th floors in the morning between 10 and 11:20 a.m. to each take a resident for a shower and then leave shower area without disinfecting the shower chair.

(b) The home's procedure titled "Guidelines for cleaning resident's wash basins" instructs staff to clean the wash basin, use Virox wipes and return to individual vanity cupboard. During the inspection, multiple wash basins were noted to be stored on top of toilet tanks and some on the bathroom floor. One bed pan was noted to be unclean and sitting on top of a resident's over bed table, next to some snack foods. Other wash basins had water left over in them, an indication that the basin was not wiped with a Virox wipe.

A washbasin labeled 471 along with a resident's name was found in the washroom of room 218. It had water in the basin and the basin was sitting on top of the toilet tank lid. The staff working in the room who just used the basin could not explain why the basin designated for a resident in another room was being used in room 218.

(c) Resident care articles such as bed pans and urine hats are not disinfected after cleaning as per the home's policy titled "Guidelines for cleaning urinals and bedpans - daily". No liquid disinfectant was observed in any soiled utility room where cleaning and disinfection takes place and no liquid disinfectant could be located in any other room on the various floors other than in locked housekeeping closets which are not accessible to personal support workers. The policy

regarding the cleaning process describes that staff are to apply a disinfectant to the articles after they are removed from the dish washer. The Director of Care reported that she assumed that staff are retrieving spray bottles from the housekeeping closet and has not audited or evaluated the process to determine how the items are disinfected and with what products. The home's policy and procedure does not provide any information as to what type of disinfectant to use, where to acquire the disinfectant or where it should be stored.

Issued on this 12th day of September, 2012

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