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
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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
Oct 23, 24 + Nov. 1 2012.	2012_189120_0006	Critical Incident

Licensee/Titulaire de permis

MARYBAN HOLDINGS LTD
3700 BILLINGS COURT, BURLINGTON, ON, L7N-3N6

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

OAKWOOD PARK LODGE
6747 OAKWOOD DRIVE, NIAGARA FALLS, ON, L2E-6S5

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 a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with administrator, director of care, assistant director of care, registered and non-registered staff regarding the home's infection prevention and control program.

During the course of the inspection, the inspector(s) toured common areas of the home, random resident rooms, laundry, soiled utility and tub rooms, observed hand hygiene and cleaning practices, took temperatures of a vaccine refrigerator and verified refrigeration temperature logs and reviewed infection prevention and control policies and procedures (H-002107-12)

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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. 229. Infection prevention and control program

Specifically failed to comply with the following subsections:

s. 229. (3) The licensee shall designate a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including,
(a) infectious diseases;
(b) cleaning and disinfection;
(c) data collection and trend analysis;
(d) reporting protocols; and
(e) outbreak management. O. Reg. 79/10, s. 229 (3).

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 :

[O. Reg. 79/10, s. 229(4)] The licensee did not ensure that the staff participated in the implementation of the program.

The infection prevention and control program includes practices related to cleaning, disinfection and instituting measures to manage outbreaks. The home has developed policies and procedures for staff to follow during an outbreak, however many of the practices were not instituted or implemented according to the policies.

For cleaning and disinfection practices:

a) Touch point surface cleaning (light switches, door knobs, bed rails, call bell buttons, grab bars etc) was not observed during the observation period and according to housekeeping staff, are not always cleaned on a daily basis due to various reasons. The home's policy 03-19-1 dated February 2012 aligns with the Provincial Infectious Diseases Advisory Committee's current best practices titled "Best Practices for Environmental Cleaning for Prevention and Control of Infections, 2012" and requires staff to clean these surfaces daily to help control the spread of disease causing organisms.

b) Two staff members, who were not housekeepers, were assigned touch point surface cleaning of common areas after the housekeepers completed their shift on October 23, 2012. The cleaning practices observed were not in keeping with best practices or the home's policy CIC-03-01-4 dated August 2011 which specifically states that cloths are not to be double dipped. Staff were observed to double dip their cleaning cloths into a bucket containing some type of disinfectant (according to staff) and water which was visibly dirty. In addition, it was observed that staff were wearing disposable gloves for this task which is not in keeping with the home's policy on appropriate glove use.

c) Housekeeping carts were observed on October 23, 24 and November 1, 2012 to be wheeled in and out of resident rooms and washrooms during their cleaning routines. The carts were visibly soiled and/or stained and housekeepers were not observed to clean their carts at the end of their shift as per their work routines. Carts were wheeled into the storage closets at the end of the shift. Housekeeping carts become contaminated during cleaning routines and become a vehicle for the transmission of disease if not cleaned daily.

For outbreak control practices:

a) The home's outbreak control policy CIC-03-02-6 dated August 2011 identifies the need for staff to draw privacy curtains between residents when in outbreak (policy does not specify if for well or unwell residents). The policy also identifies the need to leave an optimum distance of 1-2 meters between beds to reduce cross contamination. Neither of these control measures were consistently employed during the inspection. Beds in general were observed to be less than 2-3 feet apart (less than half a meter) due to over crowding in the 4-bed bedrooms. Excessive furnishings and other objects were noted in many of the 4-bed rooms.

b) Hand hygiene (use of hand gel) was not routinely performed by housekeeping staff before applying gloves or after removing gloves on October 24, 2012. Gloves were observed to be worn by a housekeeping staff member on November 1, 2012 while in the hallway pushing a cleaning cart. The home's hand hygiene policy requires that gloves be used for a single task only, when bodily fluids are expected to be present and that hand hygiene be completed before and after gloves are removed.

2. [O. Reg. 79/10 s. 229(3)(b)] The licensee has not designated a staff member to co-ordinate the program who has education and experience in infection prevention and control practices, including;

(b)cleaning and disinfection

Two staff members of the home have been designated to co-ordinate the infection prevention and control program, the Director of Care and an Infection Control Nurse. Neither of these individuals have received specific training in the area of proper cleaning methods, disinfection properties, types, use and applications.

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 staff participate in the implementation of the program, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program

Specifically failed to comply with the following subsections:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

[LTCHA 2007, S.O. 2007, c. 8, s.86(2)(b)] The infection prevention and control program must include,

(b)measures to prevent the transmission of infections.

1) The home's policies and practices related to the current tub cleaning and disinfection process does not follow the tub manufacturer's (ARJO) cleaning and disinfection instructions and does not adequately address measures to control the transmission of infectious organisms. Three of the tubs in the home are ARJO tubs and the rest are fixed standard tubs on pedestals.

The home's policy CN-C-21-1 dated May 2011 states that the tub is to be rinsed, surfaces cleaned with disinfectant (allow for contact time) and rinsed. The policy does not address the differences between the ARJO tubs and the pedestal tubs (ARJO tubs have a disinfectant dispensing system built into the units) and the policy is missing information about the type of disinfectant, how to apply the disinfectant, how long to apply the disinfectant, whether a brush is to be used and whether the tub is to receive a physical scrubbing.

A low level disinfectant called AIRX44 was identified in all tub rooms and long-handled brush was identified in some of the tub rooms. A staff member confirmed that the brush was to be used for physical cleaning purposes and the AIRX44 was to be sprayed onto the surface. However, the brush was identified to be dry after several tub baths were given on both October 24 and November 1, 2012. No physical scrubbing occurred between use. ARJO tub cleaning instructions state that the disinfectant is to be scrubbed around the surface, allowed to sit for 10 minutes and then rinsed. ARJO disinfectants provide 800 p.p.m of an active ingredient to kill organisms whereas the AIRX44 disinfectant is approximately 400 p.p.m. AIRX44 disinfectant is applied manually by hand via an an aerosol spray bottle and is inconsistently applied as opposed to using the tub's dispensing system which is applied via a hand wand and the solution is dispensed in the form of a liquid stream.

2) Staff are not washing bath basins and disinfecting them after each use in accordance with Public Health Ontario's best practices titled "Best Practices for Cleaning, Disinfection and Sterilization of all Medical Equipment/Devices in All Health Care Settings, February, 2010". Wash basins are considered to be class 1 medical devices and can be semi-critical depending on how they are used. Basins become heavily contaminated when used for incontinence cleanup, indwelling catheter care and emesis collection and if not cleaned properly become a vehicle in the spread of disease causing organisms. Staff reported that the basins are rinsed and wiped out with paper towel in the resident's washroom after use. According to the home's policy CN-C-21-1, staff are required to wash and rinse the basin, but the policy not state where this activity is to take place. There are no details about the type of disinfectant to use and how it is to be applied. Large washbasins were observed hanging on walls in resident washrooms. Some were noted to have a build-up of visible matter on the undersides where the plastic is formed into various shapes and some had residue on the inner surface. The basins are too large to be properly submerged for deep cleaning in any of the home's available sinks. The home's soiled utility rooms are not designed for cleaning and disinfection purposes. The home's policies and practices related to the current handling of soiled personal care articles does not address measures to control the transmission of infectious organisms.

3) Soiled utility rooms are structurally not designed to support the cleaning and disinfection process of personal care articles such as wash basins and bed pans. These rooms contain a small hand sink and a hopper. Both cleaned and soiled items were observed to be stored in these rooms. A wire rack open shelf was identified in each room with a bin on the shelf labeled "clean, disinfect and place in bin". Items on the identified clean shelf contained dusty and visibly soiled bed pans and commode pots. A sign posted in the room instructs staff to "dispose of waste in hopper, rinse and disinfect with RX 44". The practice of storing cleaned items in a soiled utility room is not a "best practice", due to cross contamination issues.

4) On November 1, 2012, personal support workers identified that they are required to rinse and soak heavily soiled linens or personal clothing before sending the items to the laundry room for processing. The home's policy OH-04-13-1 instructs staff to rinse and then soak heavily soiled laundry before washing. The process is to be completed in the various soiled utility rooms where there are hoppers and spray hoses available. The process of using a spray hose is not recommended according to the document titled "Best Practices for Environmental Cleaning for Prevention and Control of Infections, 2012" which states that "gross soil (e.g. feces) is removed with a gloved hand and disposed of in the toilet or

hopper and not to remove excrement by spraying with water and to handle soiled laundry with minimum of agitation to avoid contamination of the air, surfaces and persons". The soiled utility rooms are very small spaces and cleaned items stored in these rooms are easily contaminated with fecal material as they are stored on open shelves. Staff clothing can become contaminated (no gowns were noted in any soiled utility rooms to protect worker clothing)and the transmission of organisms from clothing and objects easily spreads. The home's policies and practices related to the current handling of soiled laundry does not address measures to control the transmission of infectious organisms.

5) The homes' infection and control policies CE-04-13-1 and laundry handling policies 04-13-4 and 04-14-1 direct staff to segregate soiled laundry for residents who have been identified with an "infectious organism" so they can be "washed separately". The policies direct staff to use a colour coded bag, to label the bag as "contaminated laundry" and to deposit the bag into a brown bin in the laundry room which is also labeled "contaminated laundry". According to "Routine Practices and Additional Precautions in All Health Care Settings 2011", "all linen that is soiled with blood, body fluids, secretions or excretions should be handled using the same precautions, regardless of source or health care setting". In the document titled "Best Practices for Environmental Cleaning for Prevention and Control of Infections, 2012" it states 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". The practice of segregating laundry, by collecting and storing separately and then washing separately are not required. It gives the message to staff that if laundry is not labeled as contaminated, that it must be "safe" to handle and therefore precautions are relaxed giving rise to the potential for cross-contamination and the spread of infectious organisms.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following subsections:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including loss of essential services, fire, unplanned evacuation, intake of evacuees or flooding.
2. An unexpected or sudden death, including a death resulting from an accident or suicide.
3. A resident who is missing for three hours or more.
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing.
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

[O. Reg. 79/10,s. 107(1)5.] The licensee of a long-term care home did not ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

The home failed to report a respiratory outbreak immediately as required. The outbreak was declared on October 10, 2012 and was not reported to the Director until October 17, 2012.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following subsections:

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:
1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

[O. Reg. 79/10, s.73(1)3. & 4.] The licensee of a long-term care home did not ensure that the home had a dining and snack service between October 10 and October 23, 2012 that includes, at a minimum, the following elements:

3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.

4. Monitoring of all residents during meals.

A non-influenza related respiratory outbreak was declared by Public Health in the home beginning on October 10, 2012. Residents, whether symptomatic or not were isolated to their rooms for the duration of the outbreak up until the date of inspection on October 23, 2012. The home did not employ the use of their 2 dining areas during the outbreak period for residents who were not ill.

Staff interview confirmed there is an insufficient number of staff members available to adequately monitor 153 residents residing in 61 bedrooms.

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 has a dining and snack service that includes meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise and all residents are monitored during meals, to be implemented voluntarily.

Issued on this 26th day of November, 2012

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

B. Susnik