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 prévue 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 soins de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119, rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 11, 2019	2019_539120_0021	007048-19	Complaint

Licensee/Titulaire de permis

Park Lane Terrace Limited
284 Central Avenue LONDON ON N6B 2C8

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

Park Lane Terrace
295 Grand River Street North PARIS ON N3L 2N9

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 Complaint inspection.

This inspection was conducted on the following date(s): June 12, 13, 14, 17, 2019

This complaint inspection is related to the management of residents during a gastrointestinal outbreak that was in effect from March to April 2019.

Please note non-compliance related to LTCHA s. 6(5) identified during this inspection is reflected on the complaint/follow up inspection report #2019-695156-0002, which was conducted at the same time.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Clinical Services, Associate Director of Clinical Services, Director of Environmental Services, Director of Programs and Support Services, registered nursing staff, maintenance person, housekeeping, laundry and recreational staff, personal support workers and families.

During the course of the inspection, the inspector toured all home areas, including random resident rooms, tub rooms, soiled utility rooms, common areas and outdoor spaces. Documents collected for review included recreation activity calendars and schedules, infection prevention and control, housekeeping and laundry policies and procedures, symptom surveillance forms, internal correspondence between staff and management, public health summary reports and audits and resident clinical records.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Personal Support Services
Safe and Secure Home

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

3 WN(s)
3 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

During the course of this inspection, Administrative Monetary Penalties (AMP) were not issued.

0 AMP(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 AMP – Administrative Monetary Penalty	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités AMP – Administrative Monetary Penalty
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. AMP (s) may be issued under section 156.1 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. AMP (s) may be issued under section 156.1 of the LTCHA

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was a safe and secure environment for its residents.

During the inspection, an outdoor enclosed courtyard was toured with the Director of Clinical Services (DCS) and a maintenance person. The courtyard was allocated for resident use, however it appeared that no residents were actively using the space. The access door from the resident home area lounge into the courtyard was secured. The courtyard was not in a safe or secure condition for resident use at the time of the inspection. The main gate was wide open, with no method in which to secure them. A secondary gate leading to mechanical cooling and heating equipment was closed, but not secured. A wooden gazebo located within the enclosed courtyard was accessible and was not kept in a safe condition. The concrete flooring under the carpeting was very uneven and had heaved over time. Against the gazebo, a large metal trough filled with soil was also full of water and breeding active mosquitoes. A wooden make shift bridge was not in good condition. Some of the wood post tops were jagged and a board along the path of travel had a large hole in it.

According to the maintenance person, plans were already underway to make the courtyard useable and safe for residents, however no specific dates were set. Discussion held with the DCS and maintenance person regarding the tasks that needed to be completed before residents could be permitted to use the outdoor space. [s. 5.]

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 is a safe and secure environment for its residents, 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 failed to ensure that all doors leading to non-resident areas were kept closed and locked when they were not being supervised by staff.

A non-resident area includes spaces that residents are not permitted into, such as staff areas.

On the third day of inspection, a soiled utility room door was closed, but not locked on an identified home area. The same door was propped open by a soiled linen cart three days later. No staff were present in the area at the time of the observations.

On the fourth day of inspection, a door within the main corridor (near the cafe area) leading to a servery was left unlocked. No staff were present in the dining room or the servery at the time of observation. [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-resident areas are kept closed and locked when they are not being supervised by staff, 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:

s. 229. (2) The licensee shall ensure,
(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 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. The licensee failed to ensure that the infection prevention and control program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, specifically related to cleaning and disinfection practices and gastroenteritis outbreak management protocols (including reporting).

Evidence-based practices related to cleaning and disinfection can be found in two different documents developed by the Provincial Diseases Advisory Committee on Infection Prevention and Control (PIDAC-IPC) for Public Health Ontario. One is entitled "Best Practices for Cleaning, Disinfecting and Sterilization in all Health Care Settings, May 2013" and the other is entitled “Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, 3rd Edition, April 2018”. The documents are required to be adopted and referenced when developing or updating policies, procedures and monitoring tools with respect to cleaning and disinfection routines and practices.

Prevailing practices with respect to gastroenteritis outbreak management protocols can be found in a document developed by the Ministry of Health and Long-Term Care entitled "Recommendations for the Control of Gastroenteritis in Long Term Care Homes, April 2018". The licensee is required to ensure that recommendations in this document are implemented for their gastroenteritis outbreak management program, which includes reporting.

The Executive Director identified that corporate staff were in the process of updating many policies and procedures, which are a part of the infection prevention and control program. However at the time of inspection, the infection control related policies and

procedures were last updated in May 2017, and an update in 2018 was not conducted. Several of the nurse's stations had paper copies of policies that were dated March 2012 and January 2013.

Cleaning and Disinfection

A) The home was toured on the first and fourth days of inspection, to determine compliance with current cleaning and disinfection practices for collection devices such as bed pans, wash basins (k-basins) and urinals. According to PIDAC's best practices for cleaning and disinfection, the reprocessing method, reprocessing level and cleaning/disinfection products required for the devices should reflect the intended use of the device and the potential risk of the infection involved in the use of the device.

Four personal support workers (PSW) were interviewed about their handling of wash basins and bed pans between resident use. Two PSWs stated that they washed the devices in the residents' sink with hand soap. Two PSWs stated that they used the hopper in the soiled utility room and used a disinfectant spray to clean and disinfect the device. The Director of Clinical Services and Associate Director of Clinical Services, who were hired five and three months before the inspection, were not yet aware of the practices of PSWs in the home related to handling of the devices and the use of hoppers in the home.

All five soiled utility rooms were observed for disinfection supplies and appropriate set up for cleaning. One medium sized stainless steel sink was available in each room with a counter top. One hopper (large flushing sink) was located in each soiled utility room. The sink area was not set up to accommodate cleaning or disinfection tasks. No soap, scrub brush or disinfection system was hooked up to the sink and no disinfectant products were located in four out of the five soiled utility rooms. In most of the soiled utility rooms, a laminated sign was posted identifying that the collection devices were to be cleaned daily using soap and water, followed by disinfection using a disinfectant wipe or Virox (spray). Weekly, staff were to take soiled bedpans and urinals to a soiled utility room, spray and scrub the devices with Virox for 5 minutes, rinse them and store them in an assigned area. No direction was included as to where exactly the devices were to be cleaned. Virox, a low level disinfectant, was no longer used in the home and was replaced with a similar product.

According to the home's policy entitled "Cleaning and Disinfecting Equipment" dated May 2017, bed pans, urinals and K-basins were to be cleaned in the hopper with soap, water

and a scrubber. The hopper, being a receptacle for bodily fluids and waste, was designed to be used for disposal and rinsing, but not for immersion cleaning. The written procedure identified cleaning the devices with soap and a scrub brush and gave examples of what products to use, which were all disinfectants from different companies not available in the home. Specific instructions included how to disinfect the scrub brush and to return the scrub brush to the soiled utility room [scrub brush however was already being used in the soiled utility room].

The posted procedures were not aligned with the written procedures. Neither set of procedures were sufficient to adequately direct staff as to when the devices would be disposed of, when they would require disinfection vs routine cleaning only, how specifically the disinfectant or cleaners would be used and applied (sprayed, immersed, wiped on with disposable wipe) and the required contact time, where they would be cleaned (sink, appropriate washer, resident washroom, etc) and how they would be stored between use. Non-critical devices, if not handled properly can act as vehicles for the transmission of organisms, from one body area to another (in the case when wash basins used for bed baths) and from staff hands to other surfaces.

The licensee's program for cleaning and disinfecting re-useable devices was not evaluated and updated in accordance with current evidence based practices.

B) During the inspection, observations were made of several housekeeping carts in use on different home areas. Three carts included an empty bucket with a toilet brush inside, hanging from the side of the cart. Each housekeeper was asked about how the brushes were handled, especially during enteric outbreaks. According to the housekeepers, each resident toilet was cleaned using the same brush and was rinsed in the toilet and then sprayed with disinfectant after use. One housekeeper had a different style of cart and toilet brush holder. The holder included disinfectant in which the brush was soaking between room cleaning. The Director of Environmental Services (DES) reported that housekeepers soaked their brushes in disinfectant overnight.

According to PIDAC's environmental cleaning best practices, toilet brushes should not be carried from resident room to resident room and should be dedicated to residents who have an antibiotic resistant organism. No direction in the best practices was provided with respect to cleaning or disinfecting brushes. The risks associated with using one toilet brush from room to room would require a risk assessment by an individual with infection control experience and appropriate control measures implemented to prevent the spread of organisms from room to room. Factors would also include feasibility of

leaving a toilet brush in every resident washroom and the concerns associated with monitoring and cleaning over 100 toilet brushes.

The licensee's overall program did not include any written procedures regarding the handling of toilet brushes, especially during enteric outbreaks or for residents who have an antibiotic resistant organism.

C) The DES confirmed that during the enteric outbreak in March 2019, whereby it appeared that the organism causing enteric related symptoms was highly communicable and affected 43 residents, housekeeping staff continued to use the same low level disinfectant they used on a daily basis. The product was appropriate for all enteric-related pathogens, however it had a prolonged contact time of five minutes. During the inspection, housekeepers were observed to be using microfiber cloths that were pre-soaked in the disinfectant. At the time, they were not overly wet when used by staff. It was suspected that the disinfectant was drying on the surface before the full five minutes.

During an audit conducted by public health nurses in April 2019, a recommendation was made to use a disinfectant product that had a shorter contact time, such as one minute. The DES purchased the product as suggested. However, the cleaning procedures did not include any specific direction for staff to use a different product during outbreaks and that they ensure that their cloths are adequately laundered, stored in a manner to be free of contamination and that they are adequately saturated with disinfectant before applying to surfaces.

D) No direction for dietary or housekeeping staff was available in the cleaning procedures for either department related to disinfection procedures of dining tables, chairs and items shared by residents on the table. An audit conducted by two public health nurses in April 2019, included that they observed a lack of disinfection procedures for dining room tables, chairs and shared table items. Based on routine cleaning practices, dietary staff were responsible for sanitizing these surfaces. A sanitizer cannot kill enteric related pathogens. The homes policies and procedures for cleaning during outbreaks did not include dining room furnishings and that staff change their product from a sanitizer to a disinfectant during outbreaks.

Outbreak Management Protocols

A) The licensee's "Management of an Outbreak" policy dated May 2017, combines both

respiratory and gastroenteritis control measures in one policy and refers the reader to the Provincial Infection Control Disease's Advisory Committee's (PIDAC) "Guide to Gastroenteritis Outbreak in a LTC Home" for gastroenteritis related outbreaks. This document however was not developed by PIDAC and the title was incorrect. The document that staff should have been referred to is entitled "Recommendations for the Control of Gastroenteritis in Long-Term Care Homes, April 2018", which was developed by the Ministry of Health and Long-Term Care. The information in the licensee's outbreak policy is not reflective of the MOHLTC recommendations and does not provide adequate guidance in dealing with a gastroenteritis outbreak, which includes but is not limited to control measures for visitors, volunteers, staff, resident management (whether well or ill within home areas), communication protocols, role of public health, reporting procedures, provincial case definitions, difference between a suspect vs a confirmed outbreak and post outbreak summary activities.

B) An enteric or gastrointestinal outbreak was initially reported to public health in March 2019, and to the MOHLTC two days later. The incident report to the MOHLTC included 10 confirmed resident cases. According to public health documents, they received initial notice that seven residents were affected, with six of them from one home area. The outbreak line listing form that was submitted by staff to public health identified that more than two residents were identified to have begun showing enteric-related symptoms three and four days prior to the date of submission. Based on provincial case definitions for gastroenteritis, in order to be considered a case, a resident has to have two or more episodes of specific enteric-related symtpoms within a 24 hour period. In order for public health to declare an outbreak, there must be two suspect cases on the same unit within a 48 hour period. In this case, an outbreak should have been reported four days earlier. The licensee's outbreak management protocols did not include any information regarding suspect vs confirmed cases, and what factors needed to be taken into consideration when deciding which resident met the case definition.

C) The control measures related to the enteric outbreak that were communicated to registered staff in March 2019, were in accordance with both public health and MOHLTC recommendations related to managing residents who presented with enteric-related symptoms. These included isolating symptomatic residents to their room until symptom free for 48 hours, providing tray service for ill residents (or if able, ability to eat in a designated dining room on their unit), keeping activities on each unit, and ensuring that residents remained in isolation until the DCS or ADCS were consulted. The licensee's written procedure dated May 2017, for outbreak management included additional measures such as visiting only one resident while in the home and that residents would

be confined to their rooms whenever possible. The circumstances or factors that required resident "confinement" to their rooms was not outlined in the written outbreak protocol. Internal communication between the Director of Programs and Support Services and their staff in January 2019, for a respiratory outbreak, included direction for one to one connections and small intimate group programs to continue. Similar guidance was not included in any written outbreak protocols. No guidance was included in any internal correspondence or the written outbreak protocols regarding how to manage well or ill residents with behaviours [who are not able to follow directions], whether ill residents could continue to receive assessments or if they could attend a common area if feeling fine and were at low risk of transmitting any pathogens.

D) The notification that was provided to families for the enteric outbreak in March 2019, included the need to refrain from visiting sick residents, to not visit if the visitor was ill and that all activities would cease. The message did not include any information about visitor rules while visiting, and that residents, both well and ill could continue to receive visitors as long as the visitors followed certain precautions. Two separate family members were interviewed regarding the notification and were confused by the message when they received it and were not sure if they could visit. The home's policy entitled "Visiting as it Relates to Infection Control" dated January 2013, was found in an infection control binder at a nurse's station and it was identified to be in accordance with the MOHLTC's recommendations, however it was last updated in 2013, and was no longer available in the home's digital policy library. The most current policy entitled "Routine Practices" dated May 2017, included a subsection listed as "4.11" entitled "Education of Residents, Visitors, Families", but no outbreak specific information was included. A formal communication and notification policy or procedure was not included in the licensee's outbreak management protocol.

E) Review of complaint log #007048-19 submitted to the MOHLTC in April 2019, included a concern from a complainant for resident #001 that they were unnecessarily isolated for an extended period of time during an outbreak in 2019. The complainant alleged that the resident was not cared for, or included in any activities during the isolation period; and that the management of the home claimed that they were following public health recommendations for resident isolation time frames and did not have any independent decision-making authority.

Based on registered staff interviews and their clinical records, resident #001 was placed into isolation on a specified date in 2019, due to unexplained non-outbreak symptoms as well as three episodes of specific outbreak-related symptoms over a 24 hour period. The

resident was appropriately isolated to their room, treated and remained in bed for a period of time. The resident was appropriately included on an outbreak line listing, along with other affected residents, which was submitted to public health. During this time, the resident's room was cleaned, the resident was cared for by PSWs and checked throughout the day and night by registered staff and was seen by a physician. No dedicated one to one activities were offered to the resident during this time based on the resident's health status.

An identified number of days after the resident was reported to be feeling well, the complainant contacted the DCS with concerns over why the resident was still in isolation. According to the complainant, they spoke with the DCS in the morning about their concerns. According to the ADCS, the resident was scheduled to be released from isolation on the same day and that registered staff were made aware of the fact in the morning. According to clinical records, the resident was officially released from isolation on the same date the complainant contacted the home with concerns and had received a visitor before noon. In general, residents who were a part of the identified outbreak were in isolation from six to eleven days.

A clinical record review revealed that resident #001 did not have any outbreak-related symptoms for three days in the identified month 2019. According to MOHLTC outbreak guidelines, any resident who initially met the case definition [two or more specific related symptoms over a 24 hour period] could be released from isolation if symptom free for 48 hours. However, the resident remained in isolation without apparent symptoms. Interview with the resident's physician, PSWs and registered staff who cared for the resident after they started to feel better, did not know why the resident was still in isolation and reported that the resident appeared well. According to activity records and interview with activation staff, no dedicated one to one activities or connections were offered and the resident was not taken to any small group activities for the identified number of days the resident was either symptom-free or feeling well. They were informed by registered staff that the resident was not to leave their room. The activation staff identified that they normally provided one to one connections with ill residents if the resident was able to participate.

According to the DCS and ADCS, daily consultations occurred between themselves and a public health nurse (PHN) throughout the outbreak. The ADCS was the lead during the identified outbreak and maintained the majority of the communication with the PHN. According to the ADCS, each day, resident cases were discussed with the PHN who subsequently made recommendations as to who should remain in isolation and who

should be cleared based on the reported symptoms. The ADCS was under the impression that the PHN's recommendations were mandatory and had to be followed and was unaware of the PHN's authority over each case. The ADCS felt that they received mixed messaging. The ADCS recalled discussing resident #001's case with the PHN before they were released from isolation, and was informed to keep the resident in isolation for an additional 48 hours after reporting to the PHN that the resident had another outbreak-related symptom. The resident's clinical records did not reveal whether the identified symptom met the case definition. The ADCS did not verify with the PSW, who documented the symptom on the resident's chart whether or not the symptom met the case definition. The PSW confirmed post inspection via telephone, that although they did not recall the resident's symptom on that specific day, they were very aware of the resident and did not recall if the resident's symptom was abnormal or not on their shift on the identified date.

According to the resident's records, reviewed for two months in 2019, the resident had a history of a potential symptom, which occurred approximately once or twice a week. In order to meet the case definition to remain in isolation, specified symptoms that were routine for the resident, or due to medication use or dietary choices, needed to be ruled out. In this case, these factors did not appear to be included in the decision-making. The resident was a low risk for the identified pathogen transmission and the control measures were not proportional to the risk profile of the outbreak. The home's infection control designate [either the ADCS or DCS) was required to contact public health and consult with them, but decisions about how a resident was treated were to be balanced between their needs and rights against the risk to the health of the other residents. The home's infection control designate in the home was the person who decided when to take early precautions for any suspect outbreak, and in consultation with public health, decided what actions to take and what cases to include in the outbreak based on provincial case definitions and factors such as diet, medication use, history and other health conditions. The level of confinement or isolation was to include factors associated with the resident's mental health and their behaviours. The home's designate was most familiar with residents and could best decide when they should be isolated and balance their rights with requirements to keep an outbreak from spreading.

The role of public health and the infection control designate was limited in the licensee's outbreak management protocols and did not give adequate direction about communicating with public health representatives and who decided when residents would be isolated, for how long and what factors should be considered in deciding how residents would be isolated, taking into consideration their rights and risk to the overall

outbreak profile.

The licensee therefore failed to ensure that the infection prevention and control program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, specifically related to cleaning and disinfection practices and outbreak management protocols (including reporting). [s. 229. (2) (d)]

2. The licensee failed to ensure that all staff participated in the implementation of the program.

According to s.229(3) of Ontario Regulation 79/10, the program referred to above includes but is not limited to cleaning and disinfection practices and outbreak control measures, such as soiled linen handling to prevent the transmission of disease.

Soiled Linen Handling

A) During the third day of inspection, a hopper (large flushing sink) located in an identified home area soiled utility room was observed to contain several articles of visibly soiled clothing. Personal support worker (PSW) #019 identified that the clothing belonged to a resident and they assumed that the laundry staff would not accept soiled items unless they were rinsed before laundering. The PSW was informed that the practice of soaking heavily soiled clothing was no longer a best practice and that the process would increase the risk of disease transmission. When alternatives were provided to the PSW, they were unaware of the latest practices. Laundry aide #020, concurred that PSWs did not need to soak or rinse feces from clothing before submission to the laundry room as long as the soiled items were contained in a moisture proof bag.

PSWs #026 and #027 also confirmed that they used a hopper in order to rinse off heavily contaminated clothing or peri care cloths before sending then to laundry. They were not aware of the current best practices for handling soiled linens.

The licensee's policies entitled "Laundry Services" and "Routine Practices" both dated May 2017, included directions for staff not to use spray mechanisms to remove any fecal material from clothing or linen and to remove gross fecal soiling by gloved hand and tissue before transporting to the laundry room. There was no information relating to the use of hoppers for soaking and rinsing.

The Director of Clinical Services (DCS), when informed of the observation, was unaware that PSWs were pre-rinsing soiled items, agreed that the process was not an accepted practice.

B) Correspondence reviewed between the Associate Director of Clinical Services (ADCS) and registered staff about enteric outbreak precautions in March 2019, included direction for clothing and linen for symptomatic residents to be placed in a red soiled linen bag (as opposed to a white bag). According to the ADCS, the direction was provided by public health. The direction automatically identified a change in practice for residents who were ill. According to the licensee's policies "Laundry Services" and "Routine Practices" both dated May 2017, and evidence-based practices entitled “Best Practices for Environmental Cleaning for Prevention and Control of Infections in All Health Care Settings, 3rd Edition, April 2018”, developed by the Provincial Diseases Advisory Committee on Infection Prevention and Control (PIDAC-IPC), routine practices for handling and laundering are sufficient, regardless of the source of the linen (whether from ill or well residents) and that special handling of linen for residents on additional precautions is not routinely required.

Cleaning and Disinfection

A) During the inspection, residents #002 and #003 were identified to be on additional precautions for an antibiotic-resistant organisms. Both residents shared the same washroom with one or more residents and in order to prevent the spread of the organisms to others, an appropriate disinfection product was required to be used. Contact surfaces such as a lift, toilet seat, commode, grab bar or sink faucet used by the resident or staff member in the process of toileting or other care activities where bodily fluids were encountered, should have been disinfected. The supplies that were made available to staff in or at the entrance to the bedrooms did not include any readily available disinfectant products, specifically disinfectant disposable wipes, which are safe to keep in resident accessible areas. Both residents' washrooms and bedrooms were inspected and no disinfectant wipes were available. A tour of tub rooms and utility rooms in the vicinity of the resident rooms was conducted and no disinfectant wipes were readily available to staff. Disinfectant spray was available in the tub rooms, but the product was not easily accessible to staff while in a resident washroom.

Interview with housekeeping staff and personal support workers who were familiar with resident #002 and #003 confirmed that no disinfectant wipes were readily available to

them. PSW #027 reported that the disinfectant wipes were provided just during outbreaks, otherwise common surfaces in resident washrooms were not disinfected between resident use. The Director of Clinical Services reported during the inspection that disinfectant wipes and holders for the containers were identified as needed and plans were made to order the product.

The licensee's policy entitled "Routine Prevention and Control" under a sub title of "Droplet and Contact Precautions", included direction for staff to clean and disinfect any communal or shared equipment. Under the subtitle of "Environmental Cleaning", direction included the use of commercial, pre-packaged disinfectant wipes that were easily accessible to all staff for efficient cleaning of equipment and surfaces.

The licensee therefore did not ensure that staff were following or participated in the infection prevention and control program related to soiled linen handling and cleaning and disinfection practices. [s. 229. (4)]

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 infection prevention and control program is evaluated and updated at least annually in accordance with evidence-based practices and, if there none in accordance with prevailing practices related to cleaning and disinfection practices and gastroenteritis outbreak management protocols (including reporting), to be implemented voluntarily.

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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Issued on this 24th day of July, 2019

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

Original report signed by the inspector.