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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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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
Jan 5, 2016	2015_288549_0034	O-002411-15, O-002412-15	Follow up

Licensee/Titulaire de permis

ST. PATRICK'S HOME OF OTTAWA INC.
2865 Riverside Dr. OTTAWA ON K1V 8N5

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

ST PATRICK'S HOME
2865 RIVERSIDE DRIVE OTTAWA ON K1V 8N5

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

RENA BOWEN (549)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): December 21, 22, 23, 2015

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Housekeeping Aides (HSK Aide), Registered Nurses (RN),the Resident Assessment Instrument (RAI) Coordinator ,the Manager of Support Services, the Vice President Nursing Programs/Infection Prevention and Control Lead (VPNP/IPAC), the Chief Executive Officer (CEO).
While in the home the inspector completed a tour and reviewed resident health care records including the Medication Administration Sheets, written Plan of Care and the Kardex, Infection Prevention and Control policies and procedures, education attendance records, infection logs, the VPNP/IPAC Antibiotic Resistant Organism Surveillance and Tracking sheets and each home areas individual Antibiotic Resistant Organism Tracking sheet.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **2 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 LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (3) The licensee shall ensure that the infection prevention and control program and what is provided for under that program, including the matters required under subsection (2), comply with any standards and requirements, including required outcomes, provided for in the regulations. 2007, c. 8, s. 86. (3).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.86(3) in that

the licensee failed to ensure that the infection prevention and control program and what is provided under the programs, including the matters required under subsection (2), comply with any standards and requirements, including required outcomes, provided for in the regulations.

The Vice President Nursing Program (VPNP) is the home's Infection Prevention and Control (IPAC) Lead. The VPNP/IPAC Lead is responsible for the development and implementation of the home's Infection Prevention and Control program

In accordance with O. Reg. 79/10, s. 229(4), the licensee shall ensure that all staff participates in the implementation of the program.

1. During an interview on December 21, 2015 the VPNP/IPAC Lead indicated that the Just Clean Your Hands Program has been implemented by the home as part of the Infection Prevention and Control Program.

On December 21, 2015 the inspector was touring the home with the VPNP/IPAC Lead on the fifth floor (Wexford House) when a PSW was observed coming out of a resident's room after morning care was provided with gloves on, closed the resident's door with the soiled gloves and went down the hallway to the dirty linen cart. The PSW then lifted the lid with the soiled gloves on to put the dirty linen in the cart. The PSW went back into the resident's room. Opened the door handle with the soiled gloves and entered the resident's room and closed the door behind him. The VPNP/IPAC Lead confirmed to the inspector that the home's expectation is that staff do not wear soiled gloves in the hallway after providing care and that hand hygiene be performed after gloves are removed.

On December 21, 2015 the inspector was walking down the hallway of the first floor (Galway House) and observed the housekeeping staff come out of a resident's room and put her soiled gloves in garbage. The housekeeping staff then used the broom on the housekeeping cart at the entrance to the resident's room. Once the housekeeper put the broom back on the cleaning cart she went down to the middle of the hallway to use the Alcohol Based Hand Rub (ABHR) dispenser.

There are ABHR dispensers in each of the resident rooms and one in the middle of each hallway and one at the entrance to the each of the tub rooms.

On December 22, 2015 the inspector was walking down the corridor on the first floor

(Galway House) and observed a PSW #107 coming out of a resident's room wearing gloves after providing care to the resident. The PSW went to the soiled clothes cart lifted the handle of the cart with the soiled gloves, took the soiled gloves off and touched the garbage lid then the used the ABHR from the dispenser located in the middle of the hallway. During an interview PSW #107 indicated that she is aware that she should not be wearing soiled gloves in the hallway after providing resident care.

On December 22, 2015 while Inspector #549 was walking through the second floor (Carlow House) a PSW was observed throwing a soiled towel in the dirty linen cart then proceeding to the dining room to assist residents with breakfast without using hand hygiene.

The CEO indicated to Inspector #549 that there is approximately 350 staff employed at the home. This includes all full-time, part-time and casual staff members.

During a discussion with the VPNP/IPAC Lead it was confirmed with Inspector #549 that the staff in the home were provided Hand Hygiene education in January 2015 prior to the Resident Quality Inspection in May 2015.

A review of the hand hygiene education sign in sheets for January 2015 indicates that 195 of the approximate 350 staff members completed the annual hand hygiene program.

There have been three Hand Hygiene education sessions since January 2015 for newly hired employees between May and June 2015, the education sign in sheets indicate 30 staff attended.

The VPNP/IPAC Lead confirmed that there has been no other Hand Hygiene education sessions provided in the home.

The VPNP/IPAC Lead also indicated to the inspector that the Ottawa Public Health Unit provided an overview of infection control practices to the home in September 2015. The education sign in sheets indicated that 64 of the 350 staff members attended the education session.

The issue that all staff participates in the home's hand hygiene program was previously identified in Compliance Order #002 from the Resident Quality Inspection, Inspection No. 2015_384161_0010, Log No. O-001966-15 conducted in May 2015.

2. It was observed during the tour of the home with the VPNP/IPAC Lead that isolation carts containing Personal Protective Equipment (PPE) were located throughout the home outside of the required resident's rooms along with a posted precaution sign indicating what type of precaution is required.

During an interview with RPN#102 it was indicated to the inspector that the expectation of the home is that each resident who has a requirement for infection prevention and control precautions will have signage posted outside of their door. The signage will indicate which resident in the room requires the precaution and what the precautions are along with an isolation cart with a sufficient supply of PPE.

The RPN#102 also indicated that the PSWs are assigned by the unit RPN to ensure that the isolation carts have a sufficient supply of PPE in them at all times. The VPNP/IPAC Lead confirmed that this is the expectation of the home.

During a tour of the home inspector #549 observed the following on December 21, 2015: At a specific resident room the signage posted outside of the resident's room indicated contact precautions. The inspector observed soiled gloves sitting on top of the isolation cart outside of the resident's room.

At a specific resident room the signage posted outside of the resident's room indicated contact precautions. The inspector observed that the isolation cart did not have a supply of gowns, there was only one mask and a box of gloves was sitting on the top of the isolation cart.

At a specific resident room the signage posted outside of the resident's room indicated contact precautions. The inspector observed that the isolation cart outside of the resident's room did not have a supply of gloves in it.

At a specific room which is a shared resident room, the signage posted outside of the residents' room did not indicate which resident in the room was to have contact precautions.

At a specific room the signage posted outside of the resident's room indicated contact precautions. The isolation cart outside of the resident's room had a pile of linen on the top of the cart.

At a specific room which is a shared room; there is an isolation cart outside of the resident's room with only one mask in the cart no other supplies. There is no posted signage on the outside of the resident's room indicating what precautions are to be used for what resident.

At a specific room the signage posted outside of the resident's room indicates droplet precautions. RN #106 indicated that the signage is wrong and should indicate contact precautions. RPN#106 indicated that the resident has a contact infectious disease. The isolation cart outside of the specific room did not have a supply of gloves.Inspector #549 observed RN #106 bringing the resident's health care record into the resident's room and put it on the resident's bed. The inspector also observed approximately 3 minutes later RN#106 moved the health care record to the chair in the resident's room. RN#106 indicated to the inspector that she would wipe the binder off before she puts it back at the nursing station. The VPNP/IPAC Lead indicated that the expectation is that the resident's health care record not come into contact with any objects in the resident's room while the resident's is on contact precautions.

At a specific room the signage posted outside of the resident's room indicates droplet precautions. RN #106 indicated that the signage is wrong and should indicate contact precautions. RN#106 indicated that the resident has an infectious disease in an open area. The isolation cart outside of the resident's room has a wet face cloth sitting on top of the isolation cart. The isolation cart does not have a supply of gloves in it.

At a specific room which is a shared room the signage posted outside of the resident's room indicated contact precautions. The signage did not indicate what resident was to receive the contact precautions.

At a specific room which is a shared room the signage posted outside of the resident's room indicated contact precautions. The signage did not indicate which resident was to have contact precautions. The isolation cart outside of the resident's room had hospital gown stacked on top of it.

Resident #003 was treated for an infectious disease in September 2015. The VPNP/IPAC Lead indicated to Inspector #549 that the infection had cleared up on a specific date in November 2015. Resident #003 was treated again on a specific date in November 2015 for the same infectious disease which remains active. On a specified date in December 2015, Resident #002 was treated for a the same specific disease. Resident #002 has no history of the disease previously to this infection. Resident #003

resides on a specific floor; Resident #002 also resides on the same specific floor in a different room. The VPNP/IPAC Lead indicated to Inspector #549 that she is concerned with cross contamination of the infectious disease.

On December 22, 2015 Inspector #549 with RPN #102 observed a pair of soiled gloves between the isolation cart and the wall at a specific room. The resident in the room has a diagnosis of an infectious disease.

On December 23, 2015 Inspector #549 observed the ABHR dispenser at the entrance of Cavan House on the second floor to be empty for 2 days.

Inspector #549 toured all of the spa areas in the home on December 23, 2015 the following were observed; first floor, Glaway House there was an opened unlabelled bottle of roll on deodorant, third floor, Donegal House there was an unlabelled opened stick of Speed Stick deodorant, two opened unlabelled bottles of Natura Body Lotion, two unlabelled tubes of Dawn Mist toothpaste and one opened can of Shave Cream, on the fourth floor , Kilkenny House there was an unlabelled black hair brush with hair in it and on the fifth floor, Wexford House there was an unlabelled nail clipper.

The issue of prevention of transmission of infections was previously identified in Compliance Order #002 from the Resident Quality Inspection, Inspection No. 2015_384161_0010, Log No. O-001966-15 in May 2015.

3. On December 21, 2015, the VPNP/ IPAC lead provided the inspector with an Antibiotic Resistant Organism (ARO) Surveillance and Tracking Sheet. The IPAC Lead confirmed that the ARO Surveillance and Tracking sheet was up to date.

Inspector #549 reviewed the ARO Surveillance and Tracking Sheet and noted that the Resident in a specific room was on the list with a diagnosis of specific infectious disease. There was no isolation cart outside of the resident's room or signage. The VPNP/IPAC Lead indicated that the resident no longer required precautions.

A specified room is not listed on the ARO Surveillance and Tracking Sheet. An isolation cart is outside of the resident's room with a contact precaution sign.
RPN#102 indicate that the resident in the room has been diagnosed with a specific infectious disease.

A specified room is not listed on the ARO Surveillance and Tracking Sheet. An isolation

cart is outside of the resident's room with a contact precaution sign. RPN#102 indicated that the resident in the room has been diagnosed with a another type infectious disease.

There are three specified rooms that are all private rooms, none of these rooms are on the ARO Surveillance and Tracking Sheet. An isolation cart is outside of each of the resident's room with a precaution sign. RN#106 indicated that the residents in those rooms have all been diagnosed with an infectious disease.

A specified room is not on the ARO Surveillance and Tracking Sheet. An isolation cart is outside of the resident's room with a precaution sign. RN#106 indicated that the resident in the room has been diagnosed with an infectious disease.

On December 23, 2015 the VPNP/IPAC Lead confirmed with Inspector #549 that the expectation is that each home area submit an ARO Tracking sheet monthly to her. Inspector #549 observed that the first, second and fifth floor units do not use the home's ARO Tracking sheet.

The VPNP/IPAC Lead indicated that the expectation is that all new cases of ARO are to be reported to the VPNP/IPAC Lead immediately. The VPMP/IPAC Lead confirmed with Inspector #549 that the ARO Surveillance and Tracking Sheet is not up to date and that she is not receiving monthly tracking ARO sheets from each resident home area.

The VPNP/IPAC Lead also indicated on December 23, 2015 that she was not aware that Resident #002 was being treated for an infectious disease but was aware that Resident #003 who is on the same unit as Resident #002 was being treated for the same infectious disease. The VPNP indicated that she was not aware that Resident #004 was diagnosed with an infectious disease on a specific date in February 2015. Resident #003 has a stage 3 open wound and is on contact precautions.

During an interview on December 23, 2015 the Manager of Support Services it was indicated to Inspector #549 the he was not aware of the diagnosis of the infectious disease on the first floor. He indicated that he would normally receive the information from the nursing department and then inform his Lead Hand who communicates the information to the housekeeping staff.

On December 23, 2015 the IPAC Lead confirmed to Inspector #549 that the home indicates on the 24 hour report any resident who has any respiratory/enteric symptoms. The information is then reviewed by the VPNP/IPAC Lead who will highlight it on her

personal report. The VPNP/ IPAC Lead confirmed the individual unit respiratory/enteric symptoms are not line listed on each unit until there is an outbreak status.

The VPNP/IPAC Lead confirmed with Inspector #549 that the information gathered related to sign/symptoms indicating the presence of infections are gathered once a month for UTI's, eye infections, foot infections and wounds. However, Inspector #549 was not able to confirm the monthly analysis.

The issue of gathering information related to signs/symptoms indicating the presence of infection in residents is monitored in accordance with evidence based practices, the signs/symptoms be recorded and immediate action is taken as required. Also that the information gathered must be analyzed at least once a month to detect trends for the purpose of reducing the incidence of infections and outbreaks was previously identified in Compliance Order #002 from the Resident Quality Inspection, Inspection No. 2015_384161_0010, Log No. O-001966-15.

In summary, given the wide spread continued non-compliance as described above the Compliance Order #002 from the Resident Quality Inspection, Inspection No. 2015_384161_0010, Log No. O-001966-15 with a compliance date of September 30, 2015 is being re-issued under this order. [s. 86. (3)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

On December 21, 2015, it was observed by Inspector #549 that a specific room had an isolation cart outside of the resident's room along with a posted contact precaution sign. RPN # 102 indicated that Resident #002 is being treated for an infectious disease.

During an interview with PSW #107 on December 23, 2015, it was indicated that she is provided access to the resident's Kardex on the Point of Care software program to view the care that is to be provided to Resident #002. PSW #002 also indicated that she is able to access the complete written plan of care in the resident's health care records at the nursing station.

Inspector #549 reviewed Resident #002's current Kardex and written Plan of Care on December 22, 2015. The inspector was not able to find any entry related to the resident requiring contact precautions when providing care. PSW #107 confirmed that the Kardex and the completed written Plan of Care and Kardex that she accesses does not indicate that the resident required contact precautions when care is being provided. She indicated that she is aware of the contact precautions for Resident #002 because she works full time and knows the residents well.

On December 22, 2015, it was observed by Inspector #549 that a specific had an isolation cart outside of the resident's room along with a posted contact precaution sign. RPN# 102 indicated that Resident #003 who is in the room is being treated for an infectious disease.

Inspector #549 reviewed Resident #003's current written Plan of Care and Kardex provided by RPN #102, last revised on a specific date in November 2015. There is an entry in the written Plan of Care under focus that indicates treatment for an infectious disease on a specific body part. There is no identified planned care or directions for the resident related to the infectious disease. The Kardex did not indicate that the resident required contact precautions related to the infectious disease.

On December 23, during an interview with PSW #109 it was indicated to the inspector that the PSW was new on the floor. PSW #109 indicated that she follows the directions on the resident Kardex to provide care to the residents. PSW #109 indicated to Inspector

#549 that she is aware that the Kardex and the complete written Plan of Care does not indicate that the resident required contact precautions when care is being provided. The PSW indicated that she saw the contact precaution sign posted at the resident's door and ask another PSW for assistance in understanding the reason for the contact precautions and clarify if the resident did in fact require contact precaution. PSW #109 indicated to the inspector that it would have been very helpful to her to be able to provide care to Resident #003 if the Kardex or written Plan of Care had indicated contact precautions related to the infectious disease.

On December 23, 2015 it was observed that an isolation cart outside of Resident #004's room along with a posted contact precaution sign. RPN #103 indicated that the resident has a diagnosis of an infectious disease as the reason for the contact precautions. Inspector #549 reviewed Resident #004's current written Plan of Care and Kardex. The current written Plan of Care provided by RPN #102, last revised on a specific date in December 2015, indicated that the resident has 2 open areas that are being treated. There is no identified planned care or directions for Resident #004 related to the contact precautions due to the infectious disease.

On December 23, 2015 the VP Nursing Programs indicated that the RPN on each resident home area is responsible to ensure that the resident's written Plan of Care and Kardex is current and provides clear direction to staff and others who provide direct care to the resident.

During an interview on December 23, 2015 with the VP Nursing Programs and the RAI-Coordinator it was confirmed with Inspector #549 that Resident #002, #003 and #004's written Plan of Care and Kardex did not set out clear directions to staff and others who provide direct care to the resident related to the contact precautions due to infectious diseases.

The issue that the resident's plan of care provides clear direction and ensure that the care set out in the plan of care is provided to each resident was previously identified in Compliance Order #003 from the Resident Quality Inspection, Inspection No. 2015_384161_0010, Log No. O-001966-15, with a compliance date of September 30, 2015. Given the continued non-compliance related to the written plan of care for each resident sets out clear direction to staff and others who provide direct care to the resident is being re-issued under this order. [s. 6. (1) (c)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 6th day of January, 2016

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	RENA BOWEN (549)
Inspection No. / No de l'inspection :	2015_288549_0034
Log No. / Registre no:	O-002411-15, O-002412-15
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jan 5, 2016
Licensee / Titulaire de permis :	ST. PATRICK'S HOME OF OTTAWA INC. 2865 Riverside Dr., OTTAWA, ON, K1V-8N5
LTC Home / Foyer de SLD :	ST PATRICK'S HOME 2865 RIVERSIDE DRIVE, OTTAWA, ON, K1V-8N5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Janet Morris

To ST. PATRICK'S HOME OF OTTAWA INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2015_384161_0010, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 86. (3) The licensee shall ensure that the infection prevention and control program and what is provided for under that program, including the matters required under subsection (2), comply with any standards and requirements, including required outcomes, provided for in the regulations. 2007, c. 8, s. 86. (3).

Order / Ordre :

In order to ensure that the home's infection prevention and control complies with standards and requirements provided for in the regulations the home shall:

a) shall ensure that all staff members participate in the annual Hand Hygiene education sessions that the home provides. The education session will include a return demonstration of the learnt hand hygiene technique and when hand hygiene is required. The home will retain the attendance records of the Hand Hygiene education sign in sheets.

b) complete hand hygiene audits four times a year as per the home's Hand Hygiene policy number IX NSG J 11.00 dated June 2015. The home will retain the records of the hand hygiene audits.

c) review and educate all Registered Nursing Staff on the use of the home's shift to shift report as it relates to residents who have signs/symptoms that require to be line listed.

d) provide education for all Registered Nursing Staff on procedures and protocols of line listing signs/symptoms of infections.

e) the home's infection prevention and control lead/designate will provide a daily analysis of infections in the home and communication the results of the analysis daily to all departments in the home. The home will retain the records of the daily analysis of infections in the home.

f) the home's designated infection prevention and control lead/designate in consultation with the local public health unit will ensure that information gathered related to signs/symptoms indicating the presence of infection in residents are monitored in accordance with evidence based practices, that the signs/symptoms are recorded and that immediate action is taken as required. All infectious signs/symptoms that are recorded and monitored must be analyzed at least once a month to detect trends for the purpose of reducing the incidence of infection and outbreaks.

Grounds / Motifs :

1. The licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.86(3) in that the licensee failed to ensure that the infection prevention and control program and what is provided under the programs, including the matters required under subsection (2), comply with any standards and requirements,

including required outcomes, provided for in the regulations.

The Vice President Nursing Program (VPNP) is the home's Infection Prevention and Control (IPAC) Lead. The VPNP/IPAC Lead is responsible for the development and implementation of the home's Infection Prevention and Control program

In accordance with O. Reg. 79/10, s. 229(4), the licensee shall ensure that all staff participates in the implementation of the program.

1. During an interview on December 21, 2015 the VPNP/IPAC Lead indicated that the Just Clean Your Hands Program has been implemented by the home as part of the Infection Prevention and Control Program.

On December 21, 2015 the inspector was touring the home with the VPNP/IPAC Lead on the fifth floor (Wexford House) when a PSW was observed coming out of a resident's room after morning care was provided with gloves on, closed the resident's door with the soiled gloves and went down the hallway to the dirty linen cart. The PSW then lifted the lid with the soiled gloves on to put the dirty linen in the cart. The PSW went back into the resident's room. Opened the door handle with the soiled gloves and entered the resident's room and closed the door behind him. The VPNP/IPAC Lead confirmed to the inspector that the home's expectation is that staff do not wear soiled gloves in the hallway after providing care and that hand hygiene be performed after gloves are removed.

On December 21, 2015 the inspector was walking down the hallway of the first floor (Galway House) and observed the housekeeping staff come out of a resident's room and put her soiled gloves in garbage. The housekeeping staff then used the broom on the housekeeping cart at the entrance to the resident's room. Once the housekeeper put the broom back on the cleaning cart she went down to the middle of the hallway to use the Alcohol Based Hand Rub (ABHR) dispenser.

There are ABHR dispensers in each of the resident rooms and one in the middle of each hallway and one at the entrance to the each of the tub rooms.

On December 22, 2015 the inspector was walking down the corridor on the first floor (Galway House) and observed a PSW #107 coming out of a resident's room wearing gloves after providing care to the resident. The PSW went to the

soiled clothes cart lifted the handle of the cart with the soiled gloves, took the soiled gloves off and touched the garbage lid then the used the ABHR from the dispenser located in the middle of the hallway. During an interview PSW #107 indicated that she is aware that she should not be wearing soiled gloves in the hallway after providing resident care.

On December 22, 2015 while Inspector #549 was walking through the second floor (Carlow House) a PSW was observed throwing a soiled towel in the dirty linen cart then proceeding to the dining room to assist residents with breakfast without using hand hygiene.

The CEO indicated to Inspector #549 that there is approximately 350 staff employed at the home. This includes all full-time, part-time and casual staff members.

During a discussion with the VPNP/IPAC Lead it was confirmed with Inspector #549 that the staff in the home were provided Hand Hygiene education in January 2015 prior to the Resident Quality Inspection in May 2015.

A review of the hand hygiene education sign in sheets for January 2015 indicates that 195 of the approximate 350 staff members completed the annual hand hygiene program.

There have been three Hand Hygiene education sessions since January 2015 for newly hired employees between May and June 2015, the education sign in sheets indicate 30 staff attended.

The VPNP/IPAC Lead confirmed that there has been no other Hand Hygiene education sessions provided in the home.

The VPNP/IPAC Lead also indicated to the inspector that the Ottawa Public Health Unit provided an overview of infection control practices to the home in September 2015. The education sign in sheets indicated that 64 of the 350 staff members attended the education session.

The issue that all staff participates in the home's hand hygiene program was previously identified in Compliance Order #002 from the Resident Quality Inspection, Inspection No. 2015_384161_0010, Log No. O-001966-15 conducted in May 2015.

2. It was observed during the tour of the home with the VPNP/IPAC Lead that isolation carts containing Personal Protective Equipment (PPE) were located throughout the home outside of the required resident's rooms along with a posted precaution sign indicating what type of precaution is required.

During an interview with RPN#102 it was indicated to the inspector that the expectation of the home is that each resident who has a requirement for infection prevention and control precautions will have signage posted outside of their door. The signage will indicate which resident in the room requires the precaution and what the precautions are along with an isolation cart with a sufficient supply of PPE.

The RPN#102 also indicated that the PSWs are assigned by the unit RPN to ensure that the isolation carts have a sufficient supply of PPE in them at all times. The VPNP/IPAC Lead confirmed that this is the expectation of the home.

During a tour of the home inspector #549 observed the following on December 21, 2015:
At a specific room the signage posted outside of the resident's room indicated contact precautions. The inspector observed soiled gloves sitting on top of the isolation cart outside of the resident's room.

At a specific room the signage posted outside of the resident's room indicated contact precautions. The inspector observed that the isolation cart did not have a supply of gowns, there was only one mask and a box of gloves was sitting on the top of the isolation cart.

At a specific room the signage posted outside of the resident's room indicated contact precautions. The inspector observed that the isolation cart outside of the resident's room did not have a supply of gloves in it.

At a specific room is a shared resident room, the signage posted outside of the residents' room did not indicate which resident in the room was to have contact precautions.

At a specific room the signage posted outside of the resident's room indicated contact precautions. The isolation cart outside of the resident's room had a pile of linen on the top of the cart.

At a specific room which is a shared room; there is an isolation cart outside of the resident's room with only one mask in the cart no other supplies. There is no posted signage on the outside of the resident's room indicating what precautions are to be used for what resident.

At a specific room the signage posted outside of the resident's room indicates droplet precautions. RN #106 indicated that the signage is wrong and should indicate contact precautions. RPN#106 indicated that the resident has a contact infectious disease. The isolation cart outside of the room did not have a supply of gloves.Inspector #549 observed RN #106 bringing the resident's health care record into the resident's room and put it on the resident's bed. The inspector also observed approximately 3 minutes later RN#106 moved the health care record to the chair in the resident's room. RN#106 indicated to the inspector that she would wipe the binder off before she puts it back at the nursing station. The VPNP/IPAC Lead indicated that the expectation is that the resident's health care record not come into contact with any objects in the resident's room while the resident's is on contact precautions.

At a specific room the signage posted outside of the resident's room indicates droplet precautions. RN #106 indicated that the signage is wrong and should indicate contact precautions. RN#106 indicated that the resident has an infectious disease in an open area. The isolation cart outside of the resident's room has a wet face cloth sitting on top of the isolation cart. The isolation cart does not have a supply of gloves in it.

At a specific room which is a shared room the signage posted outside of the resident's room indicated contact precautions. The signage did not indicate what resident was to receive the contact precautions.

At a specific room which is a shared room the signage posted outside of the resident's room indicated contact precautions. The signage did not indicate which resident was to have contact precautions. The isolation cart outside of the resident's room had hospital gown stacked on top of it.

Resident #003 was treated for an infectious disease in September 2015. The VPNP/IPAC Lead indicated to Inspector #549 that the infectious disease had cleared up on a specific date in November 2015. Resident #003 was treated again on a specific date in November 2015 for same infectious disease which

remains active. On a specific date in December 2015, Resident #002 was treated for the same infectious disease. Resident #002 has no history of the infectious disease previously to this infection. Resident #003 resides on a specific floor; Resident #002 also resides on the same specific floor. The VPNP/IPAC Lead indicated to Inspector #549 that she is concerned with cross contamination of the infectious disease.

On December 22, 2015 Inspector #549 with RPN #102 observed a pair of soiled gloves between the isolation cart and the wall for a a specific room. The resident in the room has a diagnosis of a specific infectious disease.

On December 23, 2015 Inspector #549 observed the ABHR dispenser at the entrance of Cavan House on the second floor to be empty for 2 days.

Inspector #549 toured all of the spa areas in the home on December 23, 2015 the following were observed; first floor, Glaway House there was an opened unlabelled bottle of roll on deodorant, third floor, Donegal House there was an unlabelled opened stick of Speed Stick deodorant, two opened unlabelled bottles of Natura Body Lotion, two unlabelled tubes of Dawn Mist toothpaste and one opened can of Shave Cream, on the fourth floor , Kilkenny House there was an unlabelled black hair brush with hair in it and on the fifth floor, Wexford House there was an unlabelled nail clipper.

The issue of prevention of transmission of infections was previously identified in Compliance Order #002 from the Resident Quality Inspection, Inspection No. 2015_384161_0010, Log No. O-001966-15 in May 2015.

3. On December 21, 2015, the VPNP/ IPAC lead provided the inspector with an Antibiotic Resistant Organism (ARO) Surveillance and Tracking Sheet. The IPAC Lead confirmed that the ARO Surveillance and Tracking sheet was up to date.

Inspector #549 reviewed the ARO Surveillance and Tracking Sheet and noted that the Resident in Room # 107 was on the list with a diagnosis with a specific infectious disease. There was no isolation cart outside of the resident's room or signage. The VPNP/IPAC Lead indicated that the resident no longer required precautions.

A specific room is not listed on the ARO Surveillance and Tracking Sheet. An

isolation cart is outside of the resident's room with a contact precaution sign. RPN#102 indicate that the resident in the room has been diagnosed with a specific infectious disease.

A specific room is not listed on the ARO Surveillance and Tracking Sheet. An isolation cart is outside of the resident's room with a contact precaution sign. RPN#102 indicated that the resident in the room has been diagnosed with an different infectious disease.

There are three specific rooms that are all private rooms, none of these rooms are on the ARO Surveillance and Tracking Sheet. An isolation cart is outside of each of the resident's room with a precaution sign. RN#106 indicated that the residents in the those rooms have all been diagnosed with an infectious disease.

A specific room is not on the ARO Surveillance and Tracking Sheet. An isolation cart is outside of the resident's room with a precaution sign. RN#106 indicated that the resident in the room has been diagnosed with an infectious disease.

On December 23, 2015 the VPNP/IPAC Lead confirmed with Inspector #549 that the expectation is that each home area submit an ARO Tracking sheet monthly to her. Inspector #549 observed that the first, second and fifth floor units do not use the home's ARO Tracking sheet.

The VPNP/IPAC Lead indicated that the expectation is that all new cases of ARO are to be reported to the VPNP/IPAC Lead immediately. The VPMP/IPAC Lead confirmed with Inspector #549 that the ARO Surveillance and Tracking Sheet is not up to date and that she is not receiving monthly tracking ARO sheets from each resident home area.

The VPNP/IPAC Lead also indicated on December 23, 2015 that she was not aware that Resident #002 was being treated for an infectious disease but was aware that Resident #003 who is on the same unit as Resident #002 was being treated for the same infectious disease. The VPNP indicated that she was not aware that Resident #004 was diagnosed with an infectious disease on a specific date in February 2015. Resident #003 has a stage 3 open wounds and is on contact precautions.

During an interview on December 23, 2015 the Manager of Support Services it was indicated to Inspector #549 the he was not aware of the diagnosis of the

infectious disease on the first floor. He indicated that he would normally receive the information from the nursing department and then inform his Lead Hand who communicates the information to the housekeeping staff.

On December 23, 2015 the IPAC Lead confirmed to Inspector #549 that the home indicates on the 24 hour report any resident who has any respiratory/enteric symptoms. The information is then reviewed by the VPNP/IPAC Lead who will highlight it on her personal report. The VPNP/ IPAC Lead confirmed the individual unit respiratory/enteric symptoms are not line listed on each unit until there is an outbreak status.

The VPNP/IPAC Lead confirmed with Inspector #549 that the information gathered related to sign/symptoms indicating the presence of infections are gathered once a month for UTI's, eye infections, foot infections and wounds. However, Inspector #549 was not able to confirm the monthly analysis.

The issue of gathering information related to signs/symptoms indicating the presence of infection in residents is monitored in accordance with evidence based practices, the signs/symptoms be recorded and immediate action is taken as required. Also that the information gathered must be analyzed at least once a month to detect trends for the purpose of reducing the incidence of infections and outbreaks was previously identified in Compliance Order #002 from the Resident Quality Inspection, Inspection No. 2015_384161_0010, Log No. O-001966-15.

In summary, given the wide spread continued non-compliance as described above the Compliance Order #002 from the Resident Quality Inspection, Inspection No. 2015_384161_0010, Log No. O-001966-15 with a compliance date of September 30, 2015 is being re-issued under this order. (549)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 15, 2016

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2015_384161_0010, CO #003;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident.
2007, c. 8, s. 6 (1).

Order / Ordre :

In order to ensure that there is a written plan of care for each resident that sets out clear direction to staff and others who provide direct care to the resident who have infectious diseases the home shall:

1. Identify and update the written plan of care for all residents who require infection prevention and control precautions.

2. Ensure that those residents' written plan of care provides clear direction to direct care staff related to the infection prevention and control precautions.

3. Ensure that all residents with either newly acquired infectious diseases or newly admitted residents with infectious diseases are identified and that the written plan of care provides clear direction to direct care staff related to the infection prevention and control precautions.

4. Daily monitoring/audits to be completed by the Infection Prevention and Control Lead/Designate to ensure that all residents with infectious diseases are identified in the resident's plan of care until the infectious disease is resolved.

Grounds / Motifs :

1. The licensee has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

On December 21, 2015, it was observed by Inspector #549 that a specific room had an isolation cart outside of the resident's room along with a posted contact precaution sign. RPN # 102 indicated that Resident #002 is being treated for an infectious disease.

During an interview with PSW #107 on December 23, 2015, it was indicated that she is provided access to the resident's Kardex on the Point of Care software program to view the care that is to be provided to Resident #002. PSW #002 also indicated that she is able to access the complete written plan of care in the resident's health care records at the nursing station.

Inspector #549 reviewed Resident #002's current Kardex and written Plan of Care on December 22, 2015. The inspector was not able to find any entry related to the resident requiring contact precautions when providing care. PSW #107 confirmed that the Kardex and the completed written Plan of Care and Kardex that she accesses does not indicate that the resident required contact precautions when care is being provided. She indicated that she is aware of the contact precautions for Resident #002 because she works full time and knows the residents well.

On December 22, 2015, it was observed by Inspector #549 that a specific room had an isolation cart outside of the resident's room along with a posted contact precaution sign. RPN# 102 indicated that Resident #003 who is in the room is being treated for an infectious disease.

Inspector #549 reviewed Resident #003's current written Plan of Care and Kardex provided by RPN #102, last revised on a specific date in November 2015. There is an entry in the written Plan of Care under focus that indicates a treatment for an infectious disease on a specific body part . There is no identified planned care or directions for the resident related to the infectious disease. The Kardex did not indicate that the resident required contact precautions related to the infectious disease.

On December 23, during an interview with PSW #109 it was indicated to the inspector that the PSW was new on the floor. PSW #109 indicated that she follows the directions on the resident Kardex to provide care to the residents. PSW #109 indicated to Inspector #549 that she is aware that the Kardex and the complete written Plan of Care does not indicate that the resident required

contact precautions when care is being provided. The PSW indicated that she saw the contact precaution sign posted at the resident's door and ask another PSW for assistance in understanding the reason for the contact precautions and clarify if the resident did in fact require contact precaution. PSW #109 indicated to the inspector that it would have been very helpful to her to be able to provide care to Resident #003 if the Kardex or written Plan of Care had indicated contact precautions related to the infectious disease.

On December 23, 2015 it was observed that a specific room had an isolation cart outside of Resident # 004's room along with a posted contact precaution sign. RPN #103 indicated that the resident has a diagnosis of an infectious disease as the reason for the contact precautions. Inspector #549 reviewed Resident #004's current written Plan of Care and Kardex. The current written Plan of Care provided by RPN #102, last revised on a specific date in December 2015, indicated that the resident has 2 open areas that are being treated. There is no identified planned care or directions for Resident #004 related to the contact precautions due to the infectious disease.

On December 23, 2015 the VP Nursing Programs indicated that the RPN on each resident home area is responsible to ensure that the resident's written Plan of Care and Kardex is current and provides clear direction to staff and others who provide direct care to the resident.

During an interview on December 23, 2015 with the VP Nursing Programs and the RAI- Coordinator it was confirmed with Inspector #549 that Resident #002, #003 and #004's written Plan of Care and Kardex did not set out clear directions to staff and others who provide direct care to the resident related to the contact precautions due to infectious diseases.

The issue that the resident's plan of care provides clear direction and ensure that the care set out in the plan of care is provided to each resident was previously identified in Compliance Order #003 from the Resident Quality Inspection, Inspection No. 2015_384161_0010, Log No. O-001966-15, with a compliance date of September 30, 2015. Given the continued non-compliance related to the written plan of care for each resident sets out clear direction to staff and others who provide direct care to the resident is being re-issued under this order. (549)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 03, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 5th day of January, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Rena Bowen

Service Area Office /
Bureau régional de services : Ottawa Service Area Office