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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 2, 2013	2013_189120_0082	H-000739-13	Follow up

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

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

BRIERWOOD GARDENS
425 PARK ROAD NORTH, BRANTFORD, ON, N3R-7G5

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 Follow up inspection.

This inspection was conducted on the following date(s): November 14 and 19, 2013

This review is a follow-up to non-compliance identified on June 10-14, 2013 regarding the home's infection prevention and control practices. Directives were made on Order #003 (issued on August 23, 2013, inspection report #2013-208141-0016) for the licensee to comply by September 30, 2013. Non-compliance remains outstanding, see below for further details.

During the course of the inspection, the inspector(s) spoke with the administrator, associate director of care (ADOC), director of care, environmental services manager, food services manager, registered staff and personal support workers.

During the course of the inspection, the inspector(s) toured the home, kitchen, utility rooms, tub/shower rooms, reviewed maintenance request logs, pest control logs, policies and procedures and equipment audits.

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

Infection Prevention and Control

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

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. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

The licensee has not ensured that the furnishings and equipment are maintained in a safe condition and in a good state of repair.

1. On November 14, 2013, ten night tables were identified to be in a poor state of repair and not maintained in a safe condition. The laminate on the top surface around the perimeter of the tables had chipped away, exposing a rough and ragged particle board surface below. Skin tears or splinters are a potential safety concern with the condition of the night tables in addition to the inability to clean the surfaces. The environmental services manager was aware of the condition of the night tables and reported that he had made a request with senior management to purchase new tables, beds and wardrobes. The manager provided documentation that identified that only two night tables and six wardrobes have been replaced since March 1, 2013.

During an inspection conducted on March 1, 2013, (inspection #2013-105130-0007) ten damaged night tables were identified in the home. The administrator provided documentation at that time that she had already placed an order for new furnishings. However, the purchase order identified that less than three night tables and a number of wardrobes were on order with a promise that more would be ordered. A voluntary plan of compliance was issued at the time to ensure that the home's furnishings are maintained in a good state of repair.

2. Various resident beds were tested and identified to have very loose bed rails. The bed model in these rooms were labeled as "Carroll" beds and are over 10 years of age. The rails work by pulling on a knob which releases the rail so that it can be rotated. When these rails were tested, they were observed to be very loose when in either the raised or lowered position. They were unsteady and moved substantially toward and away from the mattress, creating a large gap. Mattresses were tested on these beds and found to slide from side to side due to missing mattress keepers. These combined conditions increase the risk of residents becoming trapped between the rail and the mattress. Discussions with both a maintenance person and the environmental manager revealed that the one large screw responsible for keeping the rail in place has been replaced on this model of bed many times, but the screw does not stay tight for long because of repeated use and wear and tear on the metal holding the screw.

3. An electric bed was tested in an identified room after reports were received by staff that it was not working properly. The motor on the bed was overly noisy and would

not stay in the raised position when a resident was lying on the bed. The bed slowly lowered on it's own to it's lowest position. The environmental services manager was aware of the condition of the bed and had made a request for a new bed to be ordered. He was not certain whether replacing the motor would be warranted considering the age of the bed. No documentation could be provided that a new motor or any new beds were on order.
[s. 15(2)(c)]

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 O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has not ensured that procedures developed for floor care throughout the home has been implemented.

On November 14, 2013, the floors were observed to have build-up along the baseboards, both in corridors and in various resident rooms. Several resident bedrooms in the 300 wing, which have had their flooring material replaced with a dark sheet vinyl flooring material were discoloured (black) in areas where heavy foot traffic occurs and had paint chips and other small particles stuck to the material. It was observed that regular mopping of the floors did not remove the dirt or the particles. According to the home's deep cleaning schedule, deep cleaning of the bedrooms occurs only once every three months. One room in particular was observed to have the dirtiest looking floor and was documented as being deep cleaned on October 26, 2013. It was obvious that the deep cleaning process was not completed adequately.

A segment of flooring material in the 300 wing near the shower room was discoloured. According to staff, the flooring was stripped with the incorrect product and the surface layer was damaged. Based on the home's policy #ESP-C-60 titled "Stripping and Refinishing", it requires staff to strip and refinish the floors when build-up is observed along the edges and the floor starts to turn colour. According to the environmental services manager, he has not been able to follow a floor care program and schedule to strip or re-wax floors since February 2013 due to a lack of staffing hours to complete the work.
[s. 87(2)(a)]

2. Procedures have not been developed and implemented to address incidents of lingering and offensive odours.

Strong urine odours were identified in several areas within the home by several inspectors between November 12 and November 19, 2013. The odours were offensive and lingered, regardless of actions taken by housekeeping staff to remove visible signs of urine between November 12 and November 19, 2013.

Odours were strong and lingering in an identified room which was previously identified during an inspection in June 2013. No obvious changes were apparent to address the odours. In search of the source, a large wardrobe was relocated from beside the resident's bed and the source of the odour identified. It appeared as though urine had been left to dry on the floor on repeated occasions over the last few months. The

normally beige coloured floor tiles were dark brown. It was suspected that urine has seeped down into the flooring and under the baseboard. Staff identified the need to trial a solution on October 1, 2013, where a note was made in the maintenance log to relocate the wardrobe to another area of the room in hopes of changing the resident's behaviour. However, the wardrobe had not been relocated.

Urine odours were offensive and lingering in the 400 wing, at the end of the corridor in several corners. Staff reported that residents occasionally urinate in the corners when no staff are present and the urine is left to dry. Unless someone makes a point to look for urine, it is not cleaned until it has dried the following day by housekeeping staff. No staff have been assigned to monitor these areas on a regular basis. Only one housekeeper was observed working on November 14, 2013 who was responsible for cleaning the entire long term care home. She was not able to adequately clean any of the flooring in the home on that day.

In two identified washrooms urine odour was present and lingered over several days. No visible urine was observed. The flooring material was observed to be split near the baseboard and next to the toilet in both washrooms. The flooring splits or gaps have served to allow urine and moisture to seep down under the flooring and baseboard.

In one identified washroom, urine odour was strong, but not visibly evident. The square flooring tiles were heavily discoloured surrounding the toilet and several feet beyond it. It was evident that the tiles were stripped of any wax that may have been applied in the past and the tile had become porous, allowing stains to penetrate them. The source of the odour was suspected to be emanating from under the toilet seal, under the flooring material and possibly from under the baseboard near the toilet.
[s. 87(2)(d)]

During a previous inspection conducted on June 14, 2013, a written notification was issued on August 23, 2013 on inspection report #2013-208141-0016 for non-compliance related to odours.

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".
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 licensee implements procedures for floor care throughout the home, to be implemented voluntarily.

WN #3: 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. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

1. Measures are not in place to prevent the transmission of infections.

The infection prevention and control program must include various practices or measures to control the transmission of infections, one of which is cleaning and disinfection of communal equipment and personal care articles. Failure to do so may increase the chances that communicable pathogens spread from person to person via contaminated articles and equipment. The home has established procedures (policy #IPC-C-10-05) for cleaning and disinfecting non-critical reusable personal care articles and shared equipment, however staff are not following the procedures and management staff are not monitoring the practices of staff. Staff are required to use the soiled utility rooms to clean reusable personal care articles and to submerge and soak the articles with disinfectant (sink and or hopper identified) after each use.

Soiled bed pans, urinals and wash basins were identified under resident sinks in five identified washrooms on November 12, 2013 and again on November 14, 2013. It was obvious that the articles were not cleaned after use. Instructions have been provided to staff to clean after each use, however the instructions are not clear as to how they are to collect the soiled articles and how to use the existing soiled utility rooms.

Soiled utility rooms located in the 300 and 400 wings have not been arranged for staff to process re-useable plastic articles according to the home's policy and according to best practices titled "Best Practices for Cleaning, Disinfection and Sterilization in All Health Care Settings". Neither of the soiled utility rooms had any counter space or a place for articles to be dried. One large sink was available which has served to act as both a cleaning sink and hand sink and was located next to a hopper. Both soiled utility rooms had the hopper spray hose submerged in the water instead of hung on the holder. The hose is a source of fecal contamination when left in the bowl of the hopper and is used by staff on a daily basis. According to staff, they are still required to use the spray hose to wash off feces from soiled linen, a process which contaminates all surfaces and the worker. A hopper with fecal splatter on the walls and on the hopper was observed in the 300 wing on both days of the inspection. Measures have not been taken to minimize cross-contamination with respect to the use of the hopper and spray system.

The policy instructions require staff to gather the articles, but no provisions have been made as to how they are to accomplish this. Staff on night shift have been allocated the duty to collect the items, but staff have not been given any provisions to transport

the soiled articles. When the ADOC was asked what is used, bags, carts or bins, she was not aware. Instructions require staff to soak the articles in a sink or hopper, but no instructions provided to ensure staff use the correct disinfectant and that it is diluted into the sink water in an adequate amount. The utility rooms did not have any sort of chemical dispensing system. Best practice documents developed by the Provincial Infection Control Advisory Committee recommend the use of a sink and not a hopper in which to clean re-useable articles. The disinfectant that was observed in the utility rooms on November 14, 2013 was different in each of the soiled utility rooms. One room had ED disinfectant and another room had Virox 5. Both types of disinfectant were diluted into bottles, ready to use, with no mixing needed. Therefore staff were not able to dispense either product into a sink full of water. Policy instructions require staff to air dry the washed articles, yet the soiled utility rooms do not have any counter tops or shelving to be able to dry the articles properly and without re-contamination. The existing shelves were full of glass vases and other objects. The room was filled with hamper carts for soiled linens.

The formal process of monitoring staff for cleaning and disinfection practices was not established. Documentation was not available to determine when articles had been inspected for cleanliness and when staff cleaning and disinfection practices had been monitored. [s. 86(2)(b)]

Order #003 was previously issued for the above noted non-compliance on August 23, 2013, (inspection report #2013-208141-0016).

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 88. Pest control
Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. Immediate action was not taken to deal with pests.

A large colony of live ants was observed in the kitchen under the dish wash area on November 19, 2013. The area was not sanitary, with a build-up of debris on the floor. Prolonged ant activity was evident, with mounds of debris (sand, dirt) from burrowing in and around the raised grease trap cover. The food services supervisor was not aware of the issue. Staff reported in the maintenance log that ants were seen in two identified bedrooms on October 29, 2013. The home's pest control service reports were reviewed from September to November 11, 2013. No notations were made on the service reports that they were notified of any ants in the home. No ant treatments or services were applied from September to November 11, 2013. The pest control technician did not identify any ant problems, however it is not known if the technician visited the kitchen dish wash area during their monthly visits.

Immediate actions to control ants would include daily cleaning to keep food and grease off the floor and surfaces, followed by ant abatement measures (spray, traps, baiting etc). [s. 88(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 immediate action is taken to deal with pests, to be implemented voluntarily.

Issued on this 2nd day of December, 2013

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

B. Susnik

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) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2013_189120_0082
Log No. / Registre no:	H-000739-13
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Dec 2, 2013
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	BRIERWOOD GARDENS 425 PARK ROAD NORTH, BRANTFORD, ON, N3R-7G5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CATHERINE DONAHUE

To REVERA LONG TERM CARE 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)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Order / Ordre :

The licensee shall;

1. Replace all night tables that are not in good repair. Night tables that are not in good repair include but is not limited to any that have exposed particle board surfaces.
2. Install mattress keepers on all four corners of each bed.
3. Replace the motor or the bed located in the identified bedroom so that it functions as per manufacture's requirements.
4. Repair or replace the rotating assist rails on all beds that have been furnished with such a rail. The rail shall be firm and steady and not move back and forth when tested. The rails shall be monitored regularly.

The work above shall be completed by December 31, 2013.

Grounds / Motifs :

1. Previously issued as a voluntary plan of compliance on March 15, 2013, inspection report # 2013-105130-0007.

The licensee has not ensured that the furnishings and equipment are maintained in a safe condition and in a good state of repair.

1. On November 14, 2013, ten night tables were identified to be in a poor state

of repair and not maintained in a safe condition. The laminate on the top surface around the perimeter of the tables had chipped away, exposing a rough and ragged particle board surface below. Skin tears or splinters are a potential safety concern with the condition of the night tables in addition to the inability to clean the surfaces. The environmental services manager was aware of the condition of the night tables and reported that he had made a request with senior management to purchase new tables, beds and wardrobes. The manager provided documentation that identified that only two night tables and six wardrobes have been replaced since March 1, 2013.

During an inspection conducted on March 1, 2013, (inspection #2013-105130-0007) ten damaged night tables were identified in the home. The administrator provided documentation at that time that she had already placed an order for new furnishings. However, the purchase order identified that less than three night tables and a number of wardrobes were on order with a promise that more would be ordered. A voluntary plan of compliance was issued at the time to ensure that the home's furnishings are maintained in a good state of repair.

2. Various resident beds were tested and identified to have very loose bed rails. The bed model in these rooms were labeled as "Carroll" beds and are over 10 years of age. The rails work by pulling on a knob which releases the rail so that it can be rotated. When these rails were tested, they were observed to be very loose when in either the raised or lowered position. They were unsteady and moved substantially toward and away from the mattress, creating a large gap. Mattresses were tested on these beds and found to slide from side to side due to missing mattress keepers. These combined conditions increase the risk of residents becoming trapped between the rail and the mattress. Discussions with both a maintenance person and the environmental manager revealed that the one large screw responsible for keeping the rail in place has been replaced on this model of bed many times, but the screw does not stay tight for long because of repeated use and wear and tear on the metal holding the screw.

3. An electric bed was tested in one identified bedroom after reports were received by staff that it was not working properly. The motor on the bed was overly noisy and would not stay in the raised position when a resident was lying on the bed. The bed slowly lowered on it's own to it's lowest position. The environmental services manager was aware of the condition of the bed and had made a request for a new bed to be ordered. He was not certain whether

replacing the motor would be warranted considering the age of the bed. No documentation could be provided that a new motor or any new beds were on order. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2013

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces;
(c) removal and safe disposal of dry and wet garbage; and
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Order / Ordre :

The licensee shall,

1. Replace the baseboards, toilet seal and flooring material in the three identified washrooms. Once the toilet, baseboards and flooring material have been removed, the horizontal surfaces (wall board, studs) are to be inspected for any moisture damage and replaced if necessary. All surfaces are to be finished so that they are tight-fitting and impervious to moisture. The rooms are to be monitored daily for evidence of urine or moisture and cleaned and dried promptly.

2. Replace the damaged floor tiles located in the identified bedroom where urine has damaged the tile finish (left side of the resident's bed along wall). Remove the baseboard and verify that the wall surfaces behind are dry and odour-free. Replace all urine damaged materials. Seal the floor appropriately once tiles are re-installed. Monitor the room daily for evidence of urine or moisture and cleaned and dried promptly.

3. The resident's wardrobe located in the identified bedroom shall be relocated to another area of the bedroom after the damaged flooring material has been replaced.

The above work shall be completed by December 31, 2013.

Grounds / Motifs :

1. Procedures have not been developed and implemented to address incidents of lingering and offensive odours.

Strong urine odours were identified in several areas within the home by several inspectors between November 12 and November 19, 2013. The odours were offensive and lingered, regardless of actions taken by housekeeping staff to remove visible signs of urine between November 12 and November 19, 2013.

Odours were strong and lingering in an identified bedroom which was previously identified during an inspection in June 2013. No obvious changes were apparent to address the odours. In search of the source, a large wardrobe was relocated from beside the resident's bed and the source of the odour identified. It appeared as though urine had been left to dry on the floor on repeated occasions over the last few months. The normally beige coloured floor tiles

were dark brown. It was suspected that urine has seeped down into the flooring and under the baseboard. Staff identified the need to trial a solution on October 1, 2013, where a note was made in the maintenance log to relocate the wardrobe to another area of the room in hopes of changing the resident's behaviour. However, the wardrobe had not been relocated.

Urine odours were offensive and lingering in the 400 wing, at the end of the corridor in several corners. Staff reported that residents occasionally urinate in the corners when no staff are present and the urine is left to dry. Unless someone makes a point to look for urine, it is not cleaned until it has dried the following day by housekeeping staff. No staff have been assigned to monitor these areas on a regular basis. Only one housekeeper was observed working on November 14, 2013 who was responsible for cleaning the entire long term care home. She was not able to adequately clean any of the flooring in the home on that day.

In two identified washrooms urine odour was present and lingered over several days. No visible urine was observed. The flooring material was observed to be split near the baseboard and next to the toilet in both washrooms. The flooring splits or gaps have served to allow urine and moisture to seep down under the flooring and baseboard.

In one washroom, urine odour was strong, but not visibly evident. The square flooring tiles were heavily discoloured surrounding the toilet and several feet beyond it. It was evident that the tiles were stripped of any wax that may have been applied in the past and the tile had become porous, allowing stains to penetrate them. The source of the odour was suspected to be emanating from under the toilet seal, under the flooring material and possibly from under the baseboard near the toilet.

During a previous inspection conducted on June 14, 2013, a written notification was issued on August 23, 2013 on inspection report #2013-208141-0016 for non -compliance related to odours. (120)

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

Order # / Ordre no : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall amend their policy IPC-C-10-05 to include;

1. How staff are to collect soiled articles from resident's rooms, how they will transport the articles to the soiled utility rooms, how the articles will be washed in the available sink(not the hopper) in the soiled utility rooms, how the disinfection chemicals are to be used, how the articles will be air dried and returned to the resident.

2. Arrange both soiled utility rooms within the home so that staff are able to process bed pans and wash basins according to infection control best practices. The room must be designed such that staff are able to deliver soiled articles to the rooms, wash them, disinfect and air dry the articles without the potential for cross-contamination.

3. Develop a frequency schedule and audit criteria to monitor staff cleaning and disinfection practices. The audit process shall be implemented.

The above requirements are to be completed by December 31, 2013.

Grounds / Motifs :

1. Order #003 was previously issued for the following non-compliance on August 23, 2013, (inspection report #2013-208141-0016).

Measures are not in place to prevent the transmission of infections.

The infection prevention and control program must include various practices or measures to control the transmission of infections, one of which is cleaning and disinfection of communal equipment and personal care articles. Failure to do so may increase the chances that communicable pathogens spread from person to person via contaminated articles and equipment. The home has established procedures (policy #IPC-C-10-05) for cleaning and disinfecting non-critical reusable personal care articles and shared equipment, however staff are not following the procedures and management staff are not monitoring the practices of staff. Staff are required to use the soiled utility rooms to clean reusable personal care articles and to submerge and soak the articles with disinfectant (sink and or hopper identified) after each use.

Soiled bed pans, urinals and wash basins were identified under resident sinks in five identified washrooms on November 12, 2013 and again on November 14, 2013. It was obvious that the articles were not cleaned after use. Instructions have been provided to staff to clean after each use, however the instructions are not clear as to how they are to collect the soiled articles and how to use the existing soiled utility rooms.

Soiled utility rooms located in the 300 and 400 wings have not been arranged for staff to process re-useable plastic articles according to the home's policy and according to best practices titled "Best Practices for Cleaning, Disinfection and Sterilization in All Health Care Settings". Neither of the soiled utility rooms had any counter space or a place for articles to be dried. One large sink was available which has served to act as both a cleaning sink and hand sink and was located next to a hopper. Both soiled utility rooms had the hopper spray hose submerged in the water instead of hung on the holder. The hose is a source of fecal contamination when left in the bowl of the hopper and is used by staff on a daily basis. According to staff, they are still required to use the spray hose to wash off feces from soiled linen, a process which contaminates all surfaces and the worker. A hopper with fecal splatter on the walls and on the hopper was observed in the 300 wing on both days of the inspection. Measures have not been taken to minimize cross-contamination with respect to the use of the hopper and spray system.

The policy instructions require staff to gather the articles, but no provisions have been made as to how they are to accomplish this. Staff on night shift have been

allocated the duty to collect the items, but staff have not been given any provisions to transport the soiled articles. When the ADOC was asked what is used, bags, carts or bins, she was not aware. Instructions require staff to soak the articles in a sink or hopper, but no instructions provided to ensure staff use the correct disinfectant and that it is diluted into the sink water in an adequate amount. The utility rooms did not have any sort of chemical dispensing system. Best practice documents developed by the Provincial Infection Control Advisory Committee recommend the use of a sink and not a hopper in which to clean re-useable articles. The disinfectant that was observed in the utility rooms on November 14, 2013 was different in each of the soiled utility rooms. One room had ED disinfectant and another room had Virox 5. Both types of disinfectant were diluted into bottles, ready to use, with no mixing needed. Therefore staff were not able to dispense either product into a sink full of water. Policy instructions require staff to air dry the washed articles, yet the soiled utility rooms do not have any counter tops or shelving to be able to dry the articles properly and without re-contamination. The existing shelves were full of glass vases and other objects. The room was filled with hamper carts for soiled linens.

The formal process of monitoring staff for cleaning and disinfection practices was not established. Documentation was not available to determine when articles had been inspected for cleanliness and when staff cleaning and disinfection practices had been monitored.

Order #003 was previously issued for the above noted non-compliance on August 23, 2013, (inspection report #2013-208141-0016). (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2013

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 2nd day of December, 2013

Signature of Inspector / Signature de l'inspecteur : B. Susnik

Name of Inspector / Nom de l'inspecteur : BERNADETTE SUSNIK

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