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

Ministère 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) :	JESSICA LAPENSEE (133)
Inspection No. / No de l'inspection :	2013_304133_0031
Log No. / Registre no:	325-13, 309-13, 1360-12
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Nov 7, 2013
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	LAKEHEAD MANOR 135 SOUTH VICKERS STREET, THUNDER BAY, ON, P7E-1J2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jonathon Riabov

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)

Linked to Existing Order /
Lien vers ordre existant: 2013_204133_0015, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Order / Ordre :

The licensee will immediately audit the plan of care of all residents who are on enhanced infection prevention and control precautions, and ensure the reasons for the precautions are clearly outlined. This includes identification of the infection/colonization and the affected body site/body substance. The plan of care must include specific, meaningful and achievable instructions to staff, based on the actual infection/colonization and the affected body site/substance, and which are to be in accordance with evidence-based practices and the home's written policies/procedures. The staff member designated to co-ordinate the infection prevention and control program must be involved with this audit. The licensee will ensure that all staff and others who provide direct care to a resident can demonstrate their ability to access the resident's most current plan of care, including the instructions in place with regards to any current infection prevention and control precautions that have been implemented. Prior to the commencement of their shift, the licensee will ensure that staff and others who provide direct care to a resident are aware of the resident's plan of care, and have convenient and immediate access to it, in order to achieve compliance with LTCHA, 2007, S.O. 2007, c.8, s.6. (8).

Grounds / Motifs :

1. The licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.6(8) in that nursing staff members were not aware of the contents of three residents' plans of care. Specifically, registered and non-registered nursing staff involved with the care of residents #003, #004 and #001 were not aware of why these residents were on enhanced infection control practices.

2. The inspector reviewed resident #003's current plan of care (within Point Click Care), during the inspection, October 22 - 24, 2013. Within the resident profile area, in the "allergies" section, it was reflected that the resident has tested positive for Methicillin Resistant Stahylococcus Aureus (MRSA) in the nares, and for an Extended Spectrum Beta Lactamase (ESBL) producing bacteria. It was not specified what body site and/or what body fluid had tested positive for ESBL (i.e rectal swab/wound swab/urine culture..etc), within the resident profile area or elsewhere within the plan. Enhanced infection prevention and control precautions, specifically contact precautions, were in place for resident #003. Personal protective equipment (PPE) was available outside of the resident's bedroom for staff to use as needed.

On October 23, 2013, the inspector spoke with a Personal Support Worker (PSW), staff member #S103, outside of resident #003's bedroom. Staff member #S103 correctly identified that contact precautions were in place for resident #003, as opposed to their roommate, but indicated they did not know why the resident was on contact precautions. Staff member #S103 explained they normally work on a different care unit, so would ask the unit Registered Practical Nurse (RPN), or the full time PSW for the care unit, who was on break at the time, for clarification prior to providing direct care. The inspector then approached the unit RPN, staff member #S104, and asked if they could explain why resident #003 was on contact precautions. Staff member #S104 explained they do not normally work on this care unit, and they did not know why resident #003 was on contact precautions. The inspector then prompted staff member #S104 to check the resident's electronic health care record, via the computer console on their medication cart, in order to inform themselves as to why the contact precautions were in place. When the full time unit PSW, staff member #S105, returned to the unit from their break, the inspector inquired if they could explain why resident #003 was on contact precautions. Staff member #S105 stated it was due to the fact that resident #003 had tested positive for MRSA in the nose. Staff member #S105 indicated that they had participated in a staff "huddle" about resident #003, where they had been informed that the resident had tested MRSA positive in the nose, but that they had not been made aware that the resident had also tested positive for ESBL. The inspector asked staff member #S105 to explain how they would check the resident's plan of care, if needed. Staff member #S105 indicated they would check the unit "Plans of Care" binder which contains MDS Kardex reports and Point Click Care care

plans for all of the residents on the care unit. The inspector noted that the care plan for resident #003 within the binder was not the most current (print date of 9/25/2013), and did not reflect the fact that the resident had tested positive for MRSA and ESBL.

3. The inspector reviewed resident #004's current plan of care (within Point Click Care), during the inspection, October 22 - 24, 2013. Within the resident profile area, in the "allergies" section, it was documented that the resident has tested positive for MRSA. Further into the plan, it was specified that the resident had tested MRSA positive within the rectum. Enhanced infection prevention and control precautions, specifically contact precautions, were in place for resident #004. PPE was available outside of the resident's bedroom for staff to use as needed.

On October 23, 2013, the inspector spoke with a PSW, staff member #S105, who works on the resident's care unit full time. The inspector asked if the PSW could inform why contact precautions were in place for the resident. Staff member #S105 told the inspector that the resident has been in and out of hospital a lot lately, so they were on contact precautions as a precaution, but not due to an actual infection.

4. The inspector reviewed resident #001's current plan of care (within Point Click Care), during the inspection, October 22 - 24, 2013. Within the resident profile area, in the "allergies" section, it was documented that the resident had tested positive for ESBL. It was not specified what body site and/or what body fluid had tested positive for ESBL (i.e rectal swab/wound swab/urine culture..etc) within the resident profile area or elsewhere within the plan. The inspector noted that the RN 24 hour report, as well as the printed MDS Kardex report within the unit "Plans of Care" binder, which is supposed to be used as a source of reference by front line nursing staff, incorrectly identified that the resident had also tested positive, in the rectum, for Vancomycin Resistant Enterococci (VRE). Enhanced infection prevention and control precautions, specifically contact precautions, were in place for resident #001. PPE was available outside of the resident's bedroom for staff to use as needed.

On October 24th, 2013, the inspector spoke with a PSW, staff member # S100, outside of resident #001's bedroom. The PSW failed to don PPE, as required by the contact precautions in place, prior to entering the resident's washroom, with

the resident, to assist with their personal care. The inspector asked staff member #S100 if they could explain why contact precautions were supposed to be followed with resident #001. Staff member #S100 explained that they do not regularly work on the resident's care unit, that they take shifts on all of the care units and have only been employed at the home for a few months, so they have not learned everything about all the residents yet. Staff member #S100 stated that they were not aware of why contact precautions were in place for resident #001.

It is noted that non-compliance has been found with LTCHA, 2007, S.O. 2007, c.8, s.6(8) in the home's compliance history. Most recently, Compliance Order #001 was issued to the home on July 29, 2013, as a result of Follow Up inspection #2013_204133_0015
(133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 20, 2013

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2012_053122_0014, CO #915;

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 will immediately conduct a full building audit, with a focus on resident bedrooms, including furnishings, such as bedside tables, and equipment, baseboard heaters and incremental (HVAC) units. This audit is to be documented. The licensee will repair/remediate all areas specifically addressed within the grounds of this Compliance Order, and all other issues that arise as a result of the licensee's building audit, in order to ensure that the entire home and its furnishings and equipment are maintained in a safe condition and in a good state of repair. This work is to be completed by March 17th, 2014.

Grounds / Motifs :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c. 8, s. 15 (2) (c) in that the home has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. This is primarily related to observed conditions within resident bedrooms.

Over the course of the inspection, October 22nd – 24th, 2013, the inspector made the following observations in resident bedrooms:

Room 316: At the bottom right corner of one of the resident's closet, the baseboard was missing, the drywall chipped away, and the metal corner beneath was exposed.

Room 315: Above the left side of the window, in the area where the wall meets the ceiling, and on the ceiling, there was black and pink discolouration overtop of patched areas, which is suggestive of mold growth.

Room 314: At the right side of the window frame area, the paint has peeled off, the plaster beneath has cracked and crumbled away. The wall area to the immediate right, along the side of the window frame, was extensively cracked. The mid and lower corner of the wall to the right of the closet was damaged, the drywall has broken off in areas and the metal beneath was exposed.

3rd floor medication room: The wall facing the door, mid-section, was very deeply gouged.

Room 312: From within the room, the lower left corner at entrance was missing the baseboard, plaster beneath has crumbled and metal was exposed. The wall above this area, as well as on the right side, was damaged along the corners, with drywall chipped away and metal exposed.

Room 306: From within the room, a section of the baseboard (flooring material) on the lower right corner was missing, the wooden baseboard above this area was gouged, the lower wall above and along the wooden baseboard was cracked and peeling, the corner of the wall above this was missing drywall and the metal was exposed.

Room 602: Behind the bedroom door, a television cable, affixed along a section of the ceiling, hung loosely from the ceiling, around the sprinkler system enclosure. Two pieces of duct tape were noted on the loose section, which had been used at one time to affix the cord to the ceiling and/or wall in the area.

Room 601: From within the room, the baseboard for the lower right corner at the entrance was missing, drywall was crumbled and metal exposed.

Room 604: Television cable hanging loosely as described for room #602, and the lower inner washroom door was scuffed and scraped, metal beneath was exposed.

Room 603: From within the room, the lower left corner baseboard was missing,

and metal was exposed. Above this, the secondary wooden baseboard is deeply gouged. Television cable was hanging loosely, as described for room #602, yet as opposed to duct tape on the loose cord, the inspector observed attachment pins still stuck on to the hanging cord.

Room 606: The bedroom floor was stained/discoloured, pitted and gouged in areas. The wall to the right of bed 2 was gouged.

Room 608: The bedroom floor was stained/discoloured throughout.

Room 614: The television cable was hanging down loosely, as described for room #602. The residents remarked to the inspector that the loose cable has been hanging down, with the duct tape on it, for a long time.

Room 512: From within the room, a piece of the secondary wooden baseboard, right corner at entrance, was missing.

Room 509: Cable outlet cover missing on wall across from beds.

Room 504: Wall corners at entrance to the room, on both sides, were damaged, drywall chipped away and metal exposed. The lower closet doors, and wall in between, were dirty and deeply chipped and gouged, corner metal exposed. The wooden baseboard, to the left of bed B, was extensively chipped and gouged.

Room 502: Wall at the light switch was heavily damaged and metal was exposed.

Room 412: A small section of the ceiling above bed A has been damaged and was hanging down. From within the room, the lower right entrance corner was missing the black baseboard and metal was exposed. The corner of the wall above this was damaged and metal was exposed.

Room 411: From within the room, the lower right corner at entrance was missing the black baseboard and metal was exposed.

Shared resident washroom across from bedroom #414: The lower/mid wall across from the toilet and to the right of the toilet was dirty and deeply gouged.

Room 415: From within the room, the lower right corner black baseboard, at entrance, was missing. The secondary wooden baseboard above this was loose, coming away from the wall. The inner lower washroom door was deeply gouged and lower door frame chipped, metal exposed. The washroom space heater was scraped and rusty.

Room 403: The wall space between the two closets was deeply and extensively gouged, the baseboard was missing. The lower left wall corner was damaged and metal exposed.

Room 405: The bedroom floor was stained/discoloured throughout, most obviously pronounced around bed 2. The baseboard was missing at the entrance to the room, to the right of the door (from within the room).

It is to be noted that the inspector did not enter all resident bedrooms, and did not inspect all aspects of all rooms that were entered, such as washrooms and furniture.

Non compliance with O. Reg. 79/10, s.15 (2)(c) is found within the licensee's compliance history. Most recently, CO#915 was issued to the home on October 15th, 2012, as a result of Resident Quality Inspection #2012_053122_0014. (133)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Mar 17, 2014

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.

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

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 7th day of November, 2013

Signature of Inspector / Signature de l'inspecteur : Jessica Lapensée

Name of Inspector / Nom de l'inspecteur : JESSICA LAPENSEE

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

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

Sudbury Service Area Office
159 Cedar Street, Suite 403
SUDBURY, ON, P3E-6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar, Bureau 403
SUDBURY, ON, P3E-6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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
Nov 7, 2013	2013_304133_0031	325-13, 309-13, 1360-12	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

LAKEHEAD MANOR
135 SOUTH VICKERS STREET, THUNDER BAY, ON, P7E-1J2

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

JESSICA LAPENSEE (133)

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): October 22 - 24, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, the acting Director of Care, the Assistant Director of Care, the Resident Services Coordinator, the Environmental Services Manager, Registered and Non Registered Nursing Staff, and residents.

During the course of the inspection, the inspector(s) verified that exit door and stairwell doors throughout the home were secured and equipped as required, verified that unsupervised doors leading to non-residential areas were secured and equipped as required, inspected common areas and resident bedrooms with a focus on maintenance, observed front line nursing staff with a focus on adherence to infection prevention and control practices, reviewed the health care record of several residents with a focus on Antibiotic Resistant Organism infection/colonization status.

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

Infection Prevention and Control

Safe and Secure Home

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification	WN – Avis écrit
VPC – Voluntary Plan of Correction	VPC – Plan de redressement volontaire
DR – Director Referral	DR – Aiguillage au directeur
CO – Compliance Order	CO – Ordre de conformité
WAO – Work and Activity Order	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.)	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.
The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA, 2007, S.O. 2007, c.8, s.6(8) in that nursing staff members were not aware of the contents of three residents' plans of care. Specifically, registered and non-registered nursing staff involved with the care of residents #003, #004 and #001 were not aware of why these residents were on enhanced infection control practices.

2. The inspector reviewed resident #003's current plan of care (within Point Click Care), during the inspection, October 22 - 24, 2013. Within the resident profile area, in the "allergies" section, it was reflected that the resident has tested positive for Methicillin Resistant Stahylococcus Aureus (MRSA) in the nares, and for an Extended Spectrum Beta Lactamase (ESBL) producing bacteria. It was not specified what body site and/or what body fluid had tested positive for ESBL (i.e rectal swab/wound swab/urine culture..etc), within the resident profile area or elsewhere within the plan. Enhanced infection prevention and control precautions, specifically contact precautions, were in place for resident #003. Personal protective equipment (PPE) was available outside of the resident's bedroom for staff to use as needed.

On October 23, 2013, the inspector spoke with a Personal Support Worker (PSW), staff member #S103, outside of resident #003's bedroom. Staff member #S103 correctly identified that contact precautions were in place for resident #003, as opposed to their roommate, but indicated they did not know why the resident was on contact precautions. Staff member #S103 explained they normally work on a different care unit, so would ask the unit Registered Practical Nurse (RPN), or the full time PSW for the care unit, who was on break at the time, for clarification prior to providing direct care. The inspector then approached the unit RPN, staff member #S104, and asked if they could explain why resident #003 was on contact precautions. Staff member #S104 explained they do not normally work on this care unit, and they did not know why resident #003 was on contact precautions. The inspector then prompted staff member #S104 to check the resident's electronic health care record, via the computer console on their medication cart, in order to inform themselves as to why the contact precautions were in place. When the full time unit PSW, staff member #S105, returned to the unit from their break, the inspector inquired if they could explain why resident #003 was on contact precautions. Staff member #S105 stated it was due to the fact that resident #003 had tested positive for MRSA in the nose. Staff member #S105 indicated that they had participated in a staff "huddle" about resident #003, where they had been informed that the resident had tested MRSA positive in the nose, but that they had not been made aware that the resident had also tested

positive for ESBL. The inspector asked staff member #S105 to explain how they would check the resident's plan of care, if needed. Staff member #S105 indicated they would check the unit "Plans of Care" binder which contains MDS Kardex reports and Point Click Care care plans for all of the residents on the care unit. The inspector noted that the care plan for resident #003 within the binder was not the most current (print date of 9/25/2013), and did not reflect the fact that the resident had tested positive for MRSA and ESBL.

3. The inspector reviewed resident #004's current plan of care (within Point Click Care), during the inspection, October 22 - 24, 2013. Within the resident profile area, in the "allergies" section, it was documented that the resident has tested positive for MRSA. Further into the plan, it was specified that the resident had tested MRSA positive within the rectum. Enhanced infection prevention and control precautions, specifically contact precautions, were in place for resident #004. PPE was available outside of the resident's bedroom for staff to use as needed.

On October 23, 2013, the inspector spoke with a PSW, staff member #S105, who works on the resident's care unit full time. The inspector asked if the PSW could inform why contact precautions were in place for the resident. Staff member #S105 told the inspector that the resident has been in and out of hospital a lot lately, so they were on contact precautions as a precaution, but not due to an actual infection.

4. The inspector reviewed resident #001's current plan of care (within Point Click Care), during the inspection, October 22 - 24, 2013. Within the resident profile area, in the "allergies" section, it was documented that the resident had tested positive for ESBL. It was not specified what body site and/or what body fluid had tested positive for ESBL (i.e rectal swab/wound swab/urine culture..etc) within the resident profile area or elsewhere within the plan. The inspector noted that the RN 24 hour report, as well as the printed MDS Kardex report within the unit "Plans of Care" binder, which is supposed to be used as a source of reference by front line nursing staff, incorrectly identified that the resident had also tested positive, in the rectum, for Vancomycin Resistant Enterococci (VRE). Enhanced infection prevention and control precautions, specifically contact precautions, were in place for resident #001. PPE was available outside of the resident's bedroom for staff to use as needed.

On October 24th, 2013, the inspector spoke with a PSW, staff member # S100, outside of resident #001's bedroom. The PSW failed to don PPE, as required by the

contact precautions in place, prior to entering the resident's washroom, with the resident, to assist with their personal care. The inspector asked staff member #S100 if they could explain why contact precautions were supposed to be followed with resident #001. Staff member #S100 explained that they do not regularly work on the resident's care unit, that they take shifts on all of the care units and have only been employed at the home for a few months, so they have not learned everything about all the residents yet. Staff member #S100 stated that they were not aware of why contact precautions were in place for resident #001.

It is noted that non-compliance has been found with LTCHA, 2007, S.O. 2007, c.8, s.6 (8) in the home's compliance history. Most recently, Compliance Order #001 was issued to the home on July 29, 2013, as a result of Follow Up inspection #2013_204133_0015 [s. 6. (8)]

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. 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 :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c. 8, s. 15 (2)(c) in that the home has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. This is primarily related to observed conditions within resident bedrooms.

Over the course of the inspection, October 22nd – 24th, 2013, the inspector made the following observations in resident bedrooms:

Room 316: At the bottom right corner of one of the resident's closet, the baseboard was missing, the drywall chipped away, and the metal corner beneath was exposed.

Room 315: Above the left side of the window, in the area where the wall meets the ceiling, and on the ceiling, there was black and pink discolouration over top of patched areas, which is suggestive of mould growth.

Room 314: At the right side of the window frame area, the paint has peeled off, the plaster beneath has cracked and crumbled away. The wall area to the immediate right, along the side of the window frame, was extensively cracked. The mid and lower corner of the wall to the right of the closet was damaged, the drywall has broken off in areas and the metal beneath was exposed.

3rd floor medication room: The wall facing the door, mid-section, was very deeply gouged.

Room 312: From within the room, the lower left corner at entrance was missing the baseboard, plaster beneath has crumbled and metal was exposed. The wall above this area, as well as on the right side, was damaged along the corners, with drywall chipped away and metal exposed.

Room 306: From within the room, a section of the baseboard (flooring material) on the lower right corner was missing, the wooden baseboard above this area was gouged, the lower wall above and along the wooden baseboard was cracked and peeling, the corner of the wall above this was missing drywall and the metal was exposed.

Room 602: Behind the bedroom door, a television cable, affixed along a section of the ceiling, hung loosely from the ceiling, around the sprinkler system enclosure. Two pieces of duct tape were noted on the loose section, which had been used at one time

to affix the cord to the ceiling and/or wall in the area.

Room 601: From within the room, the baseboard for the lower right corner at the entrance was missing, drywall was crumbled and metal exposed.

Room 604: Television cable hanging loosely as described for room #602, and the lower inner washroom door was scuffed and scraped, metal beneath was exposed.

Room 603: From within the room, the lower left corner baseboard was missing, and metal was exposed. Above this, the secondary wooden baseboard is deeply gouged. Television cable was hanging loosely, as described for room #602, yet as opposed to duct tape on the loose cord, the inspector observed attachment pins still stuck on to the hanging cord.

Room 606: The bedroom floor was stained/discoloured, pitted and gouged in areas. The wall to the right of bed 2 was gouged.

Room 608: The bedroom floor was stained/discoloured throughout.

Room 614: The television cable was hanging down loosely, as described for room #602. The residents remarked to the inspector that the loose cable has been hanging down, with the duct tape on it, for a long time.

Room 512: From within the room, a piece of the secondary wooden baseboard, right corner at entrance, was missing.

Room 509: Cable outlet cover missing on wall across from beds.

Room 504: Wall corners at entrance to the room, on both sides, were damaged, drywall chipped away and metal exposed. The lower closet doors, and wall in between, were dirty and deeply chipped and gouged, corner metal exposed. The wooden baseboard, to the left of bed B, was extensively chipped and gouged.

Room 502: Wall at the light switch was heavily damaged and metal was exposed.

Room 412: A small section of the ceiling above bed A has been damaged and was hanging down. From within the room, the lower right entrance corner was missing the

black baseboard and metal was exposed. The corner of the wall above this was damaged and metal was exposed.

Room 411: From within the room, the lower right corner at entrance was missing the black baseboard and metal was exposed.

Shared resident washroom across from bedroom #414: The lower/mid wall across from the toilet and to the right of the toilet was dirty and deeply gouged.

Room 415: From within the room, the lower right corner black baseboard, at entrance, was missing. The secondary wooden baseboard above this was loose, coming away from the wall. The inner lower washroom door was deeply gouged and lower door frame chipped, metal exposed. The washroom space heater was scraped and rusty.

Room 403: The wall space between the two closets was deeply and extensively gouged, the baseboard was missing. The lower left wall corner was damaged and metal exposed.

Room 405: The bedroom floor was stained/discoloured throughout, most obviously pronounced around bed 2. The baseboard was missing at the entrance to the room, to the right of the door (from within the room).

It is to be noted that the inspector did not enter all resident bedrooms, and did not inspect all aspects of all rooms that were entered, such as washrooms and furniture.

Non compliance with O. Reg. 79/10, s.15 (2)(c) is found within the licensee's compliance history. Most recently, CO#915 was issued to the home on October 15th, 2012, as a result of Resident Quality Inspection #2012_053122_0014. [s. 15. (2) (c)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 229 in that not all staff participate in the implementation of the infection prevention and control program.

On October 22, 2013, during the inspection, the inspector noted that resident # 002 was identified, on the handwritten Registered Nurse (RN) 24 hour report, in the "Resident Infection Control Issues" section, as having tested positive for Vancomycin Resistant Enteroccoci (VRE), in the rectum. The inspector later went to the resident's bedroom, and observed a sign above resident # 002's picture, just outside of the bedroom door, that read "Stop, check with nursing staff before entering room". The inspector observed that there was no personal protective equipment (PPE) available for staff use, outside of resident #002's bedroom, as is the norm at the home, for residents who are on enhanced infection prevention and control precautions due to infection/colonization with antibiotic resistant organisms (ARO), such as VRE. The inspector then sought clarification from the unit Registered Practical Nurse (RPN), staff member #S101, who told the inspector that she had worked the 3-11pm shift on October 21st, 2013, and had noticed this stop sign in place at the beginning of the shift, but did not know the reason for it. Staff member #S101 further explained that towards the end of their shift, they were filing lab reports into resident charts, and had come across a report for resident #002. The report, with a date of service of October 11th 2013, and a printed date of October 16th 2013, identified that resident #002 had tested positive for Methicillin Resistant Staphylococcus Aureus (MRSA), in the rectum. The resident is not affected by VRE, despite what was noted in the RN 24 hour report. As is the norm for this home, the lab report is initially received and reviewed by one of the home's RNs, signed off by the doctor when he is next in the building, and then sent up to the unit to be filed. Staff member #S101 acknowledged that, while they were not the person who initially put up the stop sign, they had failed to follow through with the implementation of enhanced infection prevention and control precautions for resident #002 once they found out about their MRSA status. In addition, the inspector noted at this time that there was nothing documented in resident #002's health care record related to their MRSA status. The RN working at the time, staff member #S102, told the inspector that they do not typically document such things in the affected resident's health care record, but do write it on the RN 24 hour report. This report is provided to all managers and RNs, but is not provided to the RPNs or Personal Support Workers (PSWs). Normally at this home, if a resident is affected by an ARO such as VRE or MRSA, it is documented within the allergy section of the resident profile area, within the resident's electronic health care record, to allow for ready reference by the unit RPN and PSWs. [s. 229. (4)]

2. The licensee has failed to comply with O. Reg. 79/10, s. 229 in that not all staff participate in the implementation of the infection prevention and control program.

On October 24th 2013, during the inspection, the inspector observed Personal Support Worker #S100 accompany resident #001 into the resident's washroom, to assist with toileting. Resident #001 has tested positive for an Extended Spectrum Beta Lactamase (ESBL) producing bacteria. Enhanced infection prevention and control precautions are in place for resident #001. Specifically, contact precautions are in place, which require staff to don personal protective equipment (PPE), such as disposable gloves and a gown, when providing direct care to the resident. PPEs are available for staff to use, in a PPE hanger on the resident's bedroom door. The resident's care plan specifies "appropriate personal protective equipment to be donned prior to entering room, e.g. single use gown and gloves". Staff member #S100 donned gloves prior to entering the washroom with the resident, but did not don a gown. After staff member #S100 came out of the washroom, the inspector asked why they had not donned a gown. Staff member #S100 replied that they hadn't been thinking about the contact precautions, as they went in to the washroom expecting the resident would do their own personal care. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with the requirement that staff participate in the infection prevention and control (IPAC) program, specifically related to the implementation of enhanced IPAC precautions, and adherence to enhanced infection prevention and control practices, such as contact precautions, when providing direct care to affected residents,, to be implemented voluntarily.

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S)
REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 9. (1)	CO #001	2013_204133_0004	133

Issued on this 7th day of November, 2013

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

Jessica Lapensée