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
Sep 30, 2015	2015_444602_0027	O-002645-15	Resident Quality Inspection

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

HALLOWELL HOUSE
13628 LOYALIST PARKWAY PICTON ON K0K 2T0

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

WENDY BROWN (602), AMBER MOASE (541), DARLENE MURPHY (103), SUSAN DONNAN (531)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): September 14 - 18, 2015

The following inspections were conducted concurrently with the RQI:
O-001558-15 - Critical Incident (Critical Incident # 0891-000019-15)
O-002673-15 - Follow up

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Management Staff, Registered Nurses (RN), Registered Practical Nurses (RPN),
Personal Support Workers (PSW), Health Care Aids (HCA), Resident Service Coordinator, Registered Dietitian, Maintenance Supervisor, Housekeeping Staff, family members and Residents. The inspector(s) toured the home, observed resident care and services including dining and medication administration, reviewed resident health records, and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Accommodation Services - Maintenance
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours

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

7 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. (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. In regards to Log O-001558-15:

The licensee has failed to ensure there is an infection prevention and control program for the home that includes:
-daily monitoring to detect the presence of infection in residents of the long term care home and
-measures to prevent the transmission of infections.

A staff member was interviewed in regards to the availability and care of resident nail care equipment. The staff stated the home is now using individualized, labelled nail clippers and showed this inspector a storage unit in the spa area that had separate drawers for the storage of the equipment between uses. The staff stated when a new resident is admitted to the home, staff receive a new set of clippers which are then engraved with their name and that deceased residents clippers are to be discarded. Another staff stated that between uses, the clippers are soaked in disinfectant for at least ten minutes then are wiped dry and placed in the storage drawer.

Another staff was interviewed and stated s/he is a regular bath team member. S/he stated most residents do have their own labelled, nail care equipment, but on occasion resident nail care equipment may need to be shared if a new set of clippers is not available. The staff was asked how this equipment is disinfected and s/he stated the nail clippers are soaked in a solution for long periods of time and then wiped dry with a cloth. This inspector asked the staff to indicate the disinfectant being used; the solution product label identifies it is to be used for the disinfecting of non-critical instruments and devices and is not to be used as a high level disinfectant.

Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment and Devices in all Health Care Setting, 3rd Edition, Provincial Infectious Diseases Advisory Committee (PIDAC) is the prevailing best practice document in Ontario for the reprocessing of shared and/or re-usable resident care equipment. Critical equipment/devices include foot care instruments and indicates the need for meticulous cleaning of nail clippers followed by a high level disinfectant.

The DOC was interviewed in regards to the availability and care of nail care equipment and the process for disinfection of these instruments. The DOC stated the home is now using individualized, labelled nail clippers for each resident and there are individualized drawers for the storage of the equipment between uses. The DOC stated all new residents are to receive a new set of nail clippers when they are admitted and the nail equipment of deceased residents is discarded. The DOC stated the home discontinued the use of the lower level disinfectant, removed it from the home and replaced it with a high level disinfectant appropriate for the disinfection of reusable resident care equipment.

The DOC was surprised to hear in some case, nail clippers are still being shared and that they are being inadequately cleaned/disinfected using the lower level disinfectant. The DOC did acknowledge she had found nail clippers in the spa area as recently as the previous day that should have been discarded. She stated she had to reinstruct staff on the importance of discarding deceased resident nail equipment and using new nail equipment on newly admitted residents. The DOC stated it was her understanding that all of the lower level disinfectant had been taken out of the spa areas and replaced with high level disinfectant.

The soiled utility room labelled "Housekeeping" located across from the main nursing station was observed by this inspector to contain a commode chair stored in the vicinity of the hopper that is used for the cleaning of soiled equipment/clothing . The hopper was observed to have an attached spray wand which when used at full force created splash back of water.

The Administrator was asked to observe the spray wand with this inspector. When the wand was fully depressed, the inspector commented to the Administrator that water could be felt splashing onto the inspector's feet from the force of the stream hitting the water.

Staff were interviewed and confirmed the spray wand is used for the removal of

excrement from soiled articles. All of the staff interviewed did state the flow produced from this wand was much better than the previous one. One staff stated that depending on which staff member is using the spray wand, splash back can still occur. Another staff stated that s/he still uses the wand for the cleaning of soiled articles but tries to avoid depressing the wand handle to full force to minimize the force with which the water comes out.

The DOC was interviewed in regard to the presence of the commode chair in the soiled utility room. According to the DOC, the commode was awaiting repairs from an outside service provider. The DOC agreed a clean commode chair should not be stored in a dirty utility room as it increases the risk of spreading disease. The DOC stated no clean resident care equipment is to be stored in the dirty utility room.

Staff was interviewed in regards to how the home monitors for the presence of infection in residents. A registered staff stated that when two residents have similar symptoms, a line listing is started and the Public Health Unit (PHU) is notified. The registered staff stated management is responsible for notifying the PHU and identified the DOC as responsible when she is working and the Registered Nurse (RN) in charge when the DOC is not working.

Two additional registered staff were interviewed and indicated the RN's work on the secure area on a regular basis and are not always made aware of residents who may be ill from the non-secure area of the home. The registered staff indicated the home's general report (on point click care) is reviewed at the beginning of the shift for a period of 24-72 hours depending on their last shift worked in the home. Both identified challenges with this report as it also contains information about falls, behaviours and additional items. one of the registered staff stated it requires some "digging" to identify potential trends or infections that may be starting. The registered staff stated residents that become ill throughout their shift on the non-secured area of the home, are not always reported to them during their shift. They may be unaware that the threshold for the reporting of a potential disease outbreak has been exceeded or that a resident may require additional precautions.

This inspector reviewed the line listings of two recent outbreaks in the home. The first outbreak was declared on a specified date. The line listing indicated the first resident became ill nine days prior to the date the outbreak was declared. Two days prior to declaration a total of four residents were ill with similar symptoms. The PHU was notified regarding resident symptoms on the date the outbreak was declared and a total of eight

residents had become ill.

The second outbreak was declared on a specified date. This line listing was reviewed and indicated the first resident became ill seven days prior and four days prior a total of three residents were ill with similar symptoms. The PHU was notified for the first time of the symptoms on the date the outbreak was declared and as of that date there were nine ill residents.

The DOC was interviewed and advised that staff immediately take precautions with residents suspected of infectious disease, but could not explain the reason for the delay in contacting the PHU. According to O. Regs 79/10, s. 229 (5), the licensee shall ensure symptoms indicating the presence of infection in residents are monitored, the symptoms are recorded and that immediate action is taken as required.

Resident#33's health record was reviewed and it was noted the resident began to exhibit cold like symptoms on a specified date. The progress notes indicated the resident continued to exhibit symptoms and was not placed on additional precautions until 5 days later. Resident#33 was included in the second outbreak.

In addition, O. Regs 79/10, s. 229 (6) indicates the information gathered under s. 229 (5) is to be analyzed daily to detect the presence of infection. The registered staff interviews and the DOC interview revealed the home at times has poor communication between the units to ensure accurate analysis. The DOC was interviewed and was unable to provide evidence that the residents/their symptoms identified on the line listing had been thoroughly analyzed daily to detect the presence of infection in the home.

The home had a previously issued Compliance Order under LTCHA, 2007, s. 86 (2) with a compliance date of March 31, 2015. Ongoing non-compliance with regard to the disinfection of shared resident equipment (nail equipment), and improper storage of clean resident equipment was found during this inspection. Additionally, the findings related to the home's failure to analyze data daily for the presence of infection and to immediately take action in the presence of infection has a widespread scope that could jeopardize the well-being of all residents living and further supports the re-issuing of this order. [s. 86. (2)]

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. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. In regards to Log O-001558-15:

The licensee has failed to ensure the designated staff member that coordinates the infection prevention and control program has education in infection prevention and control practices including, infectious disease, cleaning and disinfection, data collection and trend analysis, reporting protocols and outbreak management.

The Director of Care is the designated infection control lead in the home and is responsible for coordinating the infection prevention and control program.

The home was previously issued an order dated January 23, 2015 to ensure the designated staff member, that coordinates the infection prevention and control program, obtained the education as required by O. Reg 79/10, s. 229 (3). This order had a compliance date of March 31, 2015.

The DOC was interviewed and stated she completed the five core competency courses offered through the local Public Health Unit (PHU) prior to the compliance date of March 31, 2015. The DOC provided an outline of the course to this inspector but was unable to provide additional information to support the inclusion of the legislated education required . The DOC stated the course she took did not include data collection and trend analysis and she was unsure if reporting protocols were included in the course.

The DOC further stated she is currently enrolled and has started a more in-depth infection control course that is offered through the Public Health Unit that does include all of the required education. The course started in September 2015 and concludes in July 2016. [s. 229. (3)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care is provided to the Resident as specified in the plan.

On a specified date at a specified time Inspector#541 was walking through the dining room and observed Resident#44 sitting in front of his/her meal and two glasses of fluid. The Resident was observed playing with his/her spoon with the food on the plate, the fluids were not touched. There was no staff present in the dining room. Approximately 10 minutes later a staff member entered the kitchen through the dining room but did not check on the Resident. Approximately 20 minutes later a registered staff entered the dining room, no assistance or encouragement was provided for Resident#44 to drink his/her fluids which remained untouched. The Resident was provided with his part of his meal which had been sitting on the plate for a minimum of 20 minutes. Resident#44 was taken out of the dining room approximately 25 minutes later with one glass of his/her fluids, the other full glass was left on the table. A few minutes later a staff was noted to clear the dining room table and remove the Resident's remaining glass of fluid.

Resident#44's current nutritional care plan indicates s/he requires verbal cueing to continue eating when consuming finger foods. The care plan also indicates the Resident can manage finger foods but requires staff to provide assistance with all other food and fluids. According to the Resident's most recent nutritional plan of care, s/he has been identified as Moderate nutritional risk and has not had a recent significant weight change.

A registered staff was asked what type of assistance Resident#44 requires and it was indicated that it depends on the day and that the Resident does not always require cueing at meals.

Care was not provided to Resident #44 as set out in the plan of care as no verbal cueing was provided to the Resident while s/he sat in the dining room, unsupervised for a minimum of 20 minutes with his/her meal and fluids. [s. 6. (7)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure there is a weight monitoring system to measure and record with respect to each resident: body mass index and height upon admission and annually thereafter.

During a census record review for forty randomly selected residents as part of the Resident Quality Inspection completed on September 14 and 15, 2015 it was found that twenty-seven of the forty residents did not have an annual height completed.

During an interview on September 17, 2015 with the Registered Dietician it was indicated that the home is currently working on a process to establish a procedure to ensure heights are completed annually. [s. 68. (2) (e) (ii)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information

Specifically failed to comply with the following:

s. 79. (3) The required information for the purposes of subsections (1) and (2) is,
(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)
(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)
(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)
(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)
(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)
(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)
(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)
(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)
(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)
(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)
(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)
(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)
(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)
(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)
(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)
(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)
(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)

Findings/Faits saillants :

1. The licensee has failed to ensure that the most recent minutes of the Family Council meetings, with the consent of the Family Council are posted in the home, in a conspicuous and easily accessible location in a manner that complies with the requirement, if any, established by the regulations.

A review of concerns provided to the licensee by the Family Council in April 2015 indicates the Family Council had requested a Family Council bulletin board. A written response provided by the Executive Director states this request is denied due to lack of funding.

On September 19, 2015 an Inspector interviewed a Family Council member who indicated the Council has been requesting a bulletin board for posting of meeting minutes for some time now; the individual stated s/he is unsure as to why the request has been denied.

On September 19, 2015 the Inspector asked members of the management team where the Family Council meetings are posted in the home and multiple members replied that the minutes are not posted.

On September 19, 2015 the Administrator's written response denying the purchase of the bulletin board citing cost and operating budget from April 2015 was reviewed with the Director of Care who states she is unaware as to why this request would be denied. It is noted the Executive Director was not available for an interview due to an off site meeting. [s. 79. (3) (o)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure there is a process to report and locate residents' lost clothing and personal items.

On September 14 and 15, 2015 forty residents were randomly selected for interviews as part of the Resident Quality Inspection being conducted at the home; during the interviews two residents shared that personal property had recently gone missing. Resident#11 shared that thirty five dollars had been found missing from a wallet approximately one month previous (August 2015). The missing property was reported and twenty of the thirty five dollars was returned. Resident#11 was not provided documentation regarding an investigation or resolution regarding the remaining fifteen dollars provided.
Resident#16 advised that his/her glasses went missing approximately one to three months ago (Summer 2015) and that the concern had been reported to Staff. The glasses have not been returned, nor has Resident#16 received documentation regarding an investigation into the issue.

On September 17, 2015, the Administrator confirmed the home's process specific to missing personal property/lost items is as follows:
- when a resident reports a concern re missing property, Staff are to respond immediately by looking for the item e.g. glasses or money.
- if the item or property isn't found, Staff usually pass the concern along verbally to co-workers, and if money is missing, Management is supposed to be alerted.
- the Resident Service Coordinator is sometimes informed as well.

Additionally, missing personal property concerns can sometimes be found noted in a communication book kept at nursing station(s) and, more recently, in an additional notebook on PSW "care carts".

The Inspector's subsequent review of July, August and September communication book entries revealed no documentation for any lost or missing items including Resident#11's missing money and Resident#16's missing glasses.

The above described process is not documented for Staff reference; Staff learn about it via word of mouth. Currently, there is no definitive process for Staff to follow specific to the reporting and locating of residents' missing personal items.

Another procedure outlined in "Management of Concerns/ Complaints/ Compliments" standard, was found in the Leadership and Partnership Manual and contained direction for Staff to complete Client Service Response (CSR) forms upon being alerted to a resident concern, complaint or compliment, however, this process is also not followed consistently. A review of the CSR form binder revealed no forms completed for Resident#11 and 16's missing property. Staff interviewed report that no formal education regarding the process(es) to follow regarding the reporting and location of residents' missing personal items.

On September 17, 2015 the Administrator acknowledged that there is no documented or consistent process currently in place, to respond to resident concerns/ complaints specific to missing personal property. [s. 89. (1) (a) (iv)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint concerning the care of a resident or operation of the home is dealt with as follows: The complaint shall be investigated and resolved where possible, and a response provided within ten business days of the receipt of the complaint.

During resident interviews, conducted on September 14 and 15, 2015 Inspectors were advised that two residents had complained that their personal property had gone missing as follows:
Resident#11: Thirty five dollars missing from wallet approximately one month previous (August 2015), the missing property was reported and twenty of the thirty five dollars was returned. There was no documentation regarding an investigation or resolution regarding the remaining fifteen dollars provided.
Resident#16: Resident#16's glasses went missing approximately one to three months ago (Summer 2015); the concern was reported to Staff but the glasses have not been returned, nor has Resident#16 received documentation regarding an investigation into the issue.

On September 16, 2015 Office Staff explained that management is made aware of complaints or concerns specific to missing personal items via a completed client service response (CSR) form and/or at a "daily report" meeting held every weekday morning where previous days' events are reviewed with management staff e.g. resident care concerns, maintenance issues, complaints, missing property etc. A subsequent review of the CSR binder revealed no completed CSR forms for Resident#11's money or Resident#16's glasses.

On September 17, 2015, the Administrator confirmed the home's process for missing personal property/lost items as follows:
- Staff are to respond immediately by looking for the item e.g. glasses or money.
- If the item is not found, Staff usually pass the concern along verbally to co-workers, and if money is missing, Management is supposed to be alerted.
- the Resident Service Coordinator is sometimes informed as well.
The concerns can be referenced, if written, in a communication book kept at nursing station(s) or another notebook now being kept on PSW "care carts".

The Administrator acknowledged that CSR forms, verbal alerts, communication and notebook entries are not consistently completed, thus complaints or concerns specific to missing personal property are not consistently investigated and resolved, nor are responses provided. [s. 101. (1) 1.]

2. The licensee has failed to ensure that the response is made to the person who made the complaint, indicating what has been done to resolve the complaint, or if it is believed that the complaint is unfounded; the reasons for the belief.

Both Resident#11 and #16 have not received a response that outlines what has been done to resolve the issue of their missing property. Resident #11 is still missing fifteen dollars and Resident#16's glasses have not been found/returned. [s. 101. (1) 3.]

Issued on this 28th day of October, 2015

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	WENDY BROWN (602), AMBER MOASE (541), DARLENE MURPHY (103), SUSAN DONNAN (531)
Inspection No. / No de l'inspection :	2015_444602_0027
Log No. / Registre no:	O-002645-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 30, 2015
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	HALLOWELL HOUSE 13628 LOYALIST PARKWAY, PICTON, ON, K0K-2T0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Leanne Weir

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2015_178102_0003, CO #001;

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 is hereby ordered to ensure all direct care staff receive education using best practice guidelines:
-in the proper cleaning and disinfection of all shared resident equipment, including appropriate use of spray wands and
-in the appropriate storage of clean resident equipment.

Develop and implement a process to ensure that:
- all registered nursing staff immediately communicate resident symptoms indicating the presence of infection and the immediate actions taken as required to the Infection Prevention and Control (IPAC) lead/Charge nurse:
- gathered information is analyzed and the IPAC lead communicates the analyzed results to the PHU as required

Grounds / Motifs :

1. The licensee has failed to ensure there is an infection prevention and control program for the home that includes:
-daily monitoring to detect the presence of infection in residents of the long term care home and
-measures to prevent the transmission of infections.

A staff member was interviewed in regards to the availability and care of resident nail care equipment. The staff stated the home is now using individualized,

labelled nail clippers and showed this inspector a storage unit in the spa area that had separate drawers for the storage of the equipment between uses. The staff stated when a new
resident is admitted to the home, staff receive a new set of clippers which are then engraved with their name and that deceased residents clippers are to be discarded. Another staff stated that between uses, the clippers are soaked in disinfectant for at least ten minutes then are wiped dry and placed in the storage drawer.

Another staff was interviewed and stated s/he is a regular bath team member. S/he stated most residents do have their own labelled, nail care equipment, but on occasion resident nail care equipment may need to be shared if a new set of clippers is not available. The staff was asked how this equipment is disinfected and s/he stated the nail clippers are soaked in a solution for long periods of time and then wiped dry with a cloth. This inspector asked the staff to indicate the disinfectant being used; the solution product label identifies it is to be used for the disinfecting of non-critical instruments and devices and is not to be used as a high level disinfectant.

Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment and Devices in all Health Care Setting, 3rd Edition, Provincial Infectious Diseases Advisory Committee (PIDAC) is the prevailing best practice document in Ontario for the reprocessing of shared and/or re-usable resident care equipment. Critical equipment/devices include foot care instruments and indicates the need for meticulous cleaning of nail clippers followed by a high level disinfectant.

The DOC was interviewed in regards to the availability and care of nail care equipment and the process for disinfection of these instruments. The DOC stated the home is now using individualized, labelled nail clippers for each resident and there are individualized drawers for the storage of the equipment between uses. The DOC stated all new residents are to receive a new set of nail clippers when they are admitted and the nail equipment of deceased residents is discarded. The DOC stated the home discontinued the use of the lower level disinfectant, removed it from the home and replaced it with a high level disinfectant appropriate for the disinfection of reusable resident care equipment.

The DOC was surprised to hear in some case, nail clippers are still being shared and that they are being inadequately cleaned/disinfected using the lower level

disinfectant. The DOC did acknowledge she had found nail clippers in the spa area as recently as the previous day that should have been discarded. She stated she had to reinstruct staff on the importance of discarding deceased resident nail equipment and using new nail equipment on newly admitted residents. The DOC stated it was her understanding that all of the lower level disinfectant had been taken out of the spa areas and replaced with high level disinfectant.

The soiled utility room labelled "Housekeeping" located across from the main nursing station was observed by this inspector to contain a commode chair stored in the vicinity of the hopper that is used for the cleaning of soiled equipment/clothing . The hopper was observed to have an attached spray wand which when used at full force created splash back of water.

The Administrator was asked to observe the spray wand with this inspector. When the wand was fully depressed, the inspector commented to the Administrator that water could be felt splashing onto the inspector's feet from the force of the stream hitting the water.

Staff were interviewed and confirmed the spray wand is used for the removal of excrement from soiled articles. All of the staff interviewed did state the flow produced from this wand was much better than the previous one. One staff stated that depending on which staff member is using the spray wand, splash back can still occur. Another staff stated that s/he still uses the wand for the cleaning of soiled articles but tries to avoid depressing the wand handle to full force to minimize the force with which the water comes out.

The DOC was interviewed in regard to the presence of the commode chair in the soiled utility room. According to the DOC, the commode was awaiting repairs from an outside service provider. The DOC agreed a clean commode chair should not be stored in a dirty utility room as it increases the risk of spreading disease. The DOC stated no clean resident care equipment is to be stored in the dirty utility room.

Staff was interviewed in regards to how the home monitors for the presence of infection in residents. A registered staff stated that when two residents have similar symptoms, a line listing is started and the Public Health Unit (PHU) is notified. The registered staff stated management is responsible for notifying the PHU and identified the DOC as responsible when she is working and the

Registered Nurse (RN) in charge when the DOC is not working.

Two additional registered staff were interviewed and indicated the RN's work on the secure area on a regular basis and are not always made aware of residents who may be ill from the non-secure area of the home. The registered staff indicated the home's general report (on point click care) is reviewed at the beginning of the shift for a period of 24-72 hours depending on their last shift worked in the home. Both identified challenges with this report as it also contains information about falls, behaviours and additional items. one of the registered staff stated it requires some "digging" to identify potential trends or infections that may be starting. The registered staff stated residents that become ill throughout their shift on the non-secured area of the home, are not always reported to them during their shift. They may be unaware that the threshold for the reporting of a potential disease outbreak has been exceeded or that a resident may require additional precautions.

This inspector reviewed the line listings of two recent outbreaks in the home. The first outbreak was declared on a specified date. The line listing indicated the first resident became ill nine days prior to the date the outbreak was declared. Two days prior to declaration a total of four residents were ill with similar symptoms. The PHU was notified regarding resident symptoms on the date the outbreak was declared and a total of eight residents had become ill.

The second outbreak was declared on a specified date. This line listing was reviewed and indicated the first resident became ill seven days prior and four days prior a total of three residents were ill with similar symptoms. The PHU was notified for the first time of the symptoms on the date the outbreak was declared and as of that date there were nine ill residents.

The DOC was interviewed and advised that staff immediately take precautions with residents suspected of infectious disease, but could not explain the reason for the delay in contacting the PHU. According to O. Regs 79/10, s. 229 (5), the licensee shall ensure symptoms indicating the presence of infection in residents are monitored, the symptoms are recorded and that immediate action is taken as required.

Resident#33's health record was reviewed and it was noted the resident began to exhibit cold like symptoms on a specified date. The progress notes indicated the resident continued to exhibit symptoms and was not placed on additional

precautions until 5 days later. Resident#33 was included in the second outbreak.

In addition, O. Regs 79/10, s. 229 (6) indicates the information gathered under s. 229 (5) is to be analyzed daily to detect the presence of infection. The registered staff interviews and the DOC interview revealed the home at times has poor communication between the units to ensure accurate analysis. The DOC was interviewed and was unable to provide evidence that the residents/their symptoms identified on the line listing had been thoroughly analyzed daily to detect the presence of infection in the home.

The home had a previously issued Compliance Order under LTCHA, 2007, s. 86 (2) with a compliance date of March 31, 2015. Ongoing non-compliance with regard to the disinfection of shared resident equipment (nail equipment), and improper storage of clean resident equipment was found during this inspection. Additionally, the findings related to the home's failure to analyze data daily for the presence of infection and to immediately take action in the presence of infection has a widespread scope that could jeopardize the well-being of all residents living and further supports the re-issuing of this order. (103)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 02, 2015

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

Order / Ordre :

The licensee is hereby ordered to ensure the staff member designated to coordinate the infection prevention and control (IPAC) program obtains education in infection prevention and control practices including:
-infectious diseases,
-cleaning and disinfection,
-data collection and trend analysis,
-reporting protocols, and
-outbreak management.

The licensee shall put in a place and implement a process to ensure the staff member designated to coordinate the IPAC program has access to a qualified IPAC consultant to support the designated staff while the required education is obtained.

Grounds / Motifs :

1. In regards to Log O-001558-15

The licensee has failed to ensure the designated staff member that coordinates the infection prevention and control program has education in infection prevention and control practices including, infectious disease, cleaning and disinfection, data collection and trend analysis, reporting protocols and outbreak management.

The Director of Care is the designated infection control lead in the home and is responsible for coordinating the infection prevention and control program.

The home was previously issued an order dated January 23, 2015 to ensure the designated staff member, that coordinates the infection prevention and control program, obtained the education as required by O. Reg 79/10, s. 229 (3). This order had a compliance date of March 31, 2015.

The DOC was interviewed and stated she completed the five core competency courses offered through the local Public Health Unit (PHU) prior to the compliance date of March 31, 2015. The DOC provided an outline of the course to this inspector but was unable to provide additional information to support the inclusion of the legislated education required. The DOC stated the course she took did not include data collection and trend analysis and she was unsure if reporting protocols were included in the course.

The DOC further stated she is currently enrolled and has started a more in-depth infection control course that is offered through the Public Health Unit that does include all of the required education. The course started in September 2015 and concludes in July 2016. (103)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 01, 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 30th day of September, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Wendy Brown

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