Ontario

Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
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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☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public

Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection
January 10,11,12, 2011	2011_113_2955_10Jan104929	Complaint Log # T-3122 and T-030

Licensee/Titulaire
Southlake Residential Care Village, 640 Grace Street, Newmarket, ON., L3Y 2L1

Long-Term Care Home/Foyer de soins de longue durée
Southlake Residential Care Village, 640 Grace Street, Newmarket, ON., L3Y 2L1

Name of Inspector(s)/Nom de l'inspecteur(s)
Jane Carruthers - #113

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct two complaint inspections regarding the management of three recent outbreaks.

During the course of the inspection, the inspector spoke with: The Administrator, Director of Care, Extendicare Clinical Environmental Health Consultant, Extendicare Director of Consulting Services, Extendicare Long Term Care Consultant, Extendicare Corporate Environmental Consultants, Registered Nursing Staff and Personal Support Workers.

During the course of the inspection, the inspector conducted a walk through of Resident Home Areas (RHA), reviewed a 24 hour nursing report and the Home's Infection Prevention and Control Manual.

The following Inspection Protocols were used in part or in whole during this inspection: Infection Prevention and Control Inspection Protocol

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

[3] WN
[3] CO: CO # 001, #002, #003

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. 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 suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with **O. Reg 79/10, s.229 (4).**
s. 229 (1) Every licensee of a long-term care home shall ensure that the infection prevention control program required under subsection 86(1) of the Act complies with the requirements of this section.
(4) The licensee shall ensure that all staff participate in the implementation of the program.

Findings:

1. Two identified shower room floors and equipment were not cleaned and disinfected after residents had been showered.
2. Shower rooms in four RHAs had no disinfectant readily available for staff to clean and disinfect equipment.
3. Toothbrushes on an identified RHA were stored improperly in washroom drawers ie loose with hair brushes.
4. Personal care items such as washbasins and bedpans were stored on the floor in resident washrooms.

Inspector ID #:	113

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with **O. Reg 79/10, s.229 (5) (b).**
The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required.

Findings:

1. Symptoms were first recorded for an outbreak on December 21, 2010 and no action was taken until December 26, 2010 when the outbreak was declared. During that time there was no collection, analysis or communication of the data to detect the new outbreak.

Inspector ID #:	113

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with **O. Reg 79/10, s. 229 (6).**
The licensee shall ensure that the information gathered under subsection (5) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks.

Findings:

1. The information gathered for the line listing on an identified RHA from December 21, 2010 to December 26, 2010 was not analyzed daily to determine the presence of infection. With no daily analysis the outbreak was not declared until there were 19 Residents identified for line listing and the Home's outbreak management was in place.

Inspector ID #:	113

Additional Required Actions:

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

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.** Irene Saunders
Title: **Date:**	**Date of Report:** (if different from date(s) of inspection). February 24, 2011

Ontario

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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

	☐ Licensee Copy/Copie du Titulaire ☒ Public Copy/Copie Public		
Name of Inspector:	Jane Carruthers	**Inspector ID #**	113
Log #:	T-3122 and T-030		
Inspection Report #:	2011_113_2955_10Jan104929		
Type of Inspection:	Complaint		
Date of Inspection:	January 10, 11, 12, 2010		
Licensee:	Southlake Residential Care Village, 640 Grace Street, Newmarket, ON L3Y 2L1		
LTC Home:	Southlake Residential Care Village, 640 Grace Street, Newmarket, ON L3Y 2L1		
Name of Administrator:	Anne Deelstra McNamara		

To Southlake Residential Care Village, you are hereby required to comply with the following orders by the dates set out below:

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: O. Reg 79/10, s.229 (4).
s. 229 (1) Every licensee of a long-term care home shall ensure that the infection prevention control program required under subsection 86(1) of the Act complies with the requirements of this section.
(4) The licensee shall ensure that all staff participate in the implementation of the program.

Order:

1. The Licensee shall ensure that all staff participate in the implementation of the Infection Prevention and Control.
2. The licensee shall educate and monitor all staff on cleaning and disinfecting practices for high contact surfaces and shared personal equipment i.e. shower chairs and commodes.
3. The licensee shall ensure that disinfecting products are readily available to staff at all times.

Grounds:
1. Two identified shower room floors and equipment were not cleaned and disinfected after residents had been showered. 2. Shower rooms in four RHAs had no disinfectant readily available for staff to clean and disinfect equipment. 3. Toothbrushes were improperly stored in washroom drawers on an identified RHA. 4. Personal care items such as washbasins and bedpans were stored on the floor in resident washrooms.

This order must be complied with by:	April 1, 2011

Order #:	002	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: O. Reg 79/10, s.229 (5) (b).
The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required.

Order:
1. The licensee shall ensure that when symptoms are identified and recorded on every shift, that immediate action is taken as required.

Grounds:
1. Symptoms were first recorded for an outbreak on an identified RHA on December 21, 2010 and no action was taken until December 26, 2010 when the outbreak was declared. During that time there was no collection, analysis or communication of the data to detect the new outbreak.

This order must be complied with by:	January 31, 2011

Order #:	003	**Order Type:**	Compliance Order, Section 153 (1)(a)

Pursuant to: O. Reg 79/10, s. 229 (6).
The licensee shall ensure that the information gathered under subsection (5) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks.

Order:
1. The licensee shall ensure that the surveillance information gathered is analyzed daily to detect the presence of infection.

Grounds:

1. The information gathered for the line listing on an identified RHA from December 21, 2010 to December 26, 2010 was not analyzed daily to determine the presence of infection. With no daily analysis the outbreak was not declared until there were 19 Residents identified for line listing and the Home's outbreak management was in place.

This order must be complied with by:	January 31, 2011

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 service for the Licensee.

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

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
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 group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board and the
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

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.

Issued on this 26th day of January, 2011.	
Signature of Inspector:	Jane Carruthers
Name of Inspector:	Jane Carruthers
Service Area Office:	Toronto Service Area