Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Division de la responsabilisation et de la performance du système de santé
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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
July 7 Jul 6, 27, Aug 15, 2011	2011_057163_0003	Complaint

Licensee/Titulaire de permis

NEW ORCHARD LODGE LIMITED
3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2

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

EXTENDICARE VAN DAELE
39 Van Daele Street, Sault Ste Marie, ON, P6B-4V3

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

DIANA STENLUND (163)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC)/Acting Administrator, Infection Control Coordinator, registered staff, personal support workers (PSWs), and residents.

During the course of the inspection, the inspector(s) Observed resident care and services on 4th floor.
Reviewed medical documentation.
Reviewed policies.

The following Inspection Protocols were used in part or in whole during this inspection:

Falls Prevention

Infection Prevention and Control

~~Prevention of Abuse, Neglect and Retaliation~~ DS

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

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Definitions	Définitions
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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.)	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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following subsections:

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 sayants :

1. The licensee failed to ensure staff participate in the implementation of the infection prevention and control program. Staff assigned a bed-ridden resident to a room with another resident who tested positive for an Antibiotic Resistant Organism (ARO), contrary to their policy to ensure staff prevent the spread of infection of AROs. The home's policy for residents with an ARO (Policy #05-01) including MRSA (Methicillin Resistant Staph Aureus) indicates "Residents with an ARO should not share a room with a resident who has (iv.) Bed bound, palliative, debilitated residents requiring high amounts of hands on care". On July 7/11 a RN was interviewed about a resident's transfer in March 2011 to another room where a resident had tested positive for ARO. The RN confirmed that when this resident was moved into a room with another resident who had an ARO, the newly moved resident "was not allowed to transfer independently or weight bear at that time".
2. The Infection Control Coordinator confirmed with the inspector on July 6, 2011 the resident who was moved was "bed bound" and was moved into a room in March 2011 with another resident who tested positive for an ARO.

Issued on this 7th day of September, 2011

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

Diana Stenlund