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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 24, 2015	2015_376594_0014	S-000519-14, S-000520-14, S-000521-14, S-000522-14	Follow up

Licensee/Titulaire de permis

LADY DUNN HEALTH CENTRE
17 Government Road Box 179 Wawa ON P0S 1K0

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

LADY DUNN HEALTH CENTRE
17 Government Road P.O. Box 179 Wawa ON P0S 1K0

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

MONIKA GRAY (594)

Inspection Summary/Résumé de l'inspection

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

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): June 01-04, 2015

This inspection was conducted concurrently with Critical Incident System Inspection 205_376594_0016 and Complaint Inspection 2015_376594_0015.

During the course of the inspection, the inspector(s) spoke with Registered Practical Nurses (RPNs), Registered Nurse (RN) and the Director of Patient Care Services and Nursing.

The inspector(s) also reviewed policies, plans of care and other documentation within the home, conducted a daily walk through of the resident care areas, observed staff to resident interactions and the delivery of care and services to the residents.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Minimizing of Restraining

During the course of this inspection, Non-Compliances were issued.
3 WN(s)
1 VPC(s)
3 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 110. (2)	CO #001	2014_339579_0013	594

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 O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that every use of a physical device to restrain a resident is documented including the person who applied the device and the time of application.

A Compliance Order was issued on November 05, 2014, during inspection 2014_339579_0013 with a compliance date of November 28, 2014; ordering the licensee to ensure that for resident #003, #004 and #005 that every use of a physical device to restrain a resident is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: the person who applied the device and the time of application.

On June 03, 2015, the inspector observed resident #003 over the course of the day with various restraints used at various times. On June 04, 2015, the inspector reviewed the resident Restraint Record which failed to document any restraint use from 0100 hours until 1900 hours.

On June 03, 2015, the inspector observed resident #004 over the course of the day with a restraint in use. On June 04, 2015, the inspector reviewed the resident Restraint Record which failed to document any restraint use from 0700 until 1900.

The inspector reviewed resident #003 and #004 restraint records for the month of May/June and for resident #005 for the month of January/February 2015 and noted various dates and times which failed to document any restraint use.

In an interview with the inspector, the DOPCSN and s#-105 stated that it is the home's expectation that staff complete documentation before the end of their shift and verified that restraint documentation from June 03 for the resident #003 and #004 had not been completed.

The Least Restraints Policy #LTC 130 VII-230 reviewed by the inspector, stated that documenting the use of restraints and PASDs the following forms shall be used: nurses notes, care plans, Consent form for Restraints, restraint assessment/physician order, restraint record and individual restraint re-assessment form. According to the same document, if a restraint renders a resident incapable of moving or repositioning themselves, the resident shall be monitored and repositioned by a member of the nursing or personal care staff. This monitoring shall be done hourly, documentation of use of restraints and checks will be done on the flow sheet. [s. 110. (7) 5.]

2. The licensee has failed to ensure that every use of a physical device to restrain a resident is documented including all assessment, reassessment and monitoring, including the resident's response.

The inspector reviewed the restraint records for resident #003 and #004 for the month of May and part of June 2015; and resident #005 for the month of January and part of February 2015. Based on this documentation, the record indicated that nursing initials are required every 8 hours and code either "N" for necessary or "NR" for no longer required; as well as documentation identifying if the restraint was applied, released, visually checked; the restraint type and the resident's response to that restraint. The inspector noted:
- For resident #003 that on May 01 - 03, 06, 07, 09 -14, 18, 19, and 23 – 28, 2015, documentation failed to identify that the resident was reassessed and that the effectiveness of the restraining evaluated at least every eight hours, and at any other time based on the resident's condition or circumstances; and that on May 01, 11, 18, 19 and June 03, 2015, there were periods of time the lack of documentation failed to identify that a restraint was removed or reapplied and the resident's response, if required.
- For resident #004 that on May 04 – 06, 10 – 12, 19, 21 and 23-28, 2015, documentation failed to identify that the resident was reassessed and that the effectiveness of the restraining evaluated at least every eight hours, and at any other time based on the

resident's condition or circumstances; and that on May 16-19, 29-30 and June 03, 2015, there were periods of time the lack of documentation failed to identify that a restraint was removed or reapplied and the resident's response, if required.
- For resident #005 that on January 04, 06, 08, 14, 15, 17 – 19, 21, 23, 24, 26 and 28, 2015, documentation failed to identify that the resident was reassessed and that the effectiveness of the restraining evaluated at least every eight hours, and at any other time based on the resident's condition or circumstances; and that on January 05, 16, 19, 23 and February 03, 2015, there were periods of time the lack of documentation failed to identify that a restraint was removed or reapplied and the resident's response, if required.

In an interview with the inspector, s#-100 stated the home's expectation is to document the effectiveness every eight hours. S#-100, s#-101 and s#103 all stated to the inspector that restraint documentation is to be completed on the restraint record.

The inspector reviewed the home's Restraint Record Audits completed during December 2014 and January 2015. According to these audits there was a pattern of failing to document assessment by an RN/RPN every eight hours; repositioning/checking (if the restraint was applied, released, visually checked, repositioned), resident response and reason for restraint.

The inspector interviewed the DOPCSN and s#-105 who confirmed that for resident #003, #004 and #005 there lacked documentation on the type of restraint applied and by whom, the resident's response and assessment by an RN/RPN. [s. 110. (7) 6.]

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. (2) The licensee shall ensure,
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly; O. Reg. 79/10, s. 229 (2).

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

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. The licensee has failed to ensure that the Infection Prevention and Control (IPAC) interdisciplinary team meet at least quarterly.

A Compliance Order was issued on November 05, 2014, during inspection 2014_339579_0013 with a compliance date of November 28, 2014; ordering the licensee to ensure that there is an interdisciplinary team that co-ordinates and implements the program and meets at least quarterly.

The inspector reviewed the IPAC Committee Meeting Minutes of 2014 – June 2015. Meetings were held on August 14, 2014; February 11 and May 20, 2015, with no date set for the next meeting.

The DOPCSN stated to the inspector in an interview, that the IPAC committee aims to hold meetings every month but at minimum occur quarterly. In an interview with the inspector, s#-107 stated meetings are held quarterly and the next meeting is scheduled for August with no specific date identified.

Review of the home's Resident Quality Inspection Report Plan of Correction dated November 17, 2014, stated that the most responsible person who the task was assigned to was s-#107 who would incorporate having at least 4 IPAC meetings per year, in the terms of reference with a deadline of November 19, 2014.

Given the licensee had a IPAC meeting in August of 2014, the compliance order was to be complied with by November 28, 2014, and the next IPAC meeting was not held until February 2015, the licensee has failed to ensure that the IAPC interdisciplinary team met at least quarterly. [s. 229. (2) (b)]

2. The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Program is evaluated and updated at least annually in accordance with evidence-based practices.

A Compliance Order was issued on November 05, 2014, during inspection 2014_339579_0013 with a compliance date of November 28, 2014; ordering the licensee to ensure that the infection prevention and control program was evaluated and updated at least annually in accordance with evidence based practices.

The inspector requested the IPAC Program evaluation from the DOPCSN who stated to the inspector that the program is scheduled to be evaluated at the next IPAC meeting.

Review of the home's Resident Quality Inspection Report Plan of Correction dated November 17, 2014, stated that the most responsible person who the task was assigned to was s-#107, who would establish time and date of next meeting of the Infection Control Committee to review the program annually and the deadline was to disseminate the necessary materials to review at next Infection prevention and control meeting on November 28, 2014.

Given that the licensee failed to comply with their own Plan of Correction and that no evaluation had been completed, the licensee failed to ensure that the infection prevention and control program was evaluated and updated at least annually in accordance with evidence based practices. [s. 229. (2) (d)]

3. The licensee has failed to ensure that there is a designated staff member to co-ordinate the infection prevention and control (IPAC) program with education and experience in infection prevention and control practices.

A Compliance Order was issued on November 05, 2014, during inspection 2014_339579_0013 with a compliance date of January 05, 2015, ordering the licensee to ensure that the designated staff member who coordinated the Infection Prevention and Control Program obtained education and experience in infection prevention and control practices including, (a) infectious disease; (b) cleaning and disinfection; (c) data collection and trend analysis; (d) reporting protocols; and (e) outbreak management.

The inspector interviewed the DOPCSN who stated s-#107 was registered in a post secondary college in the Infection Control Practitioner Program that started on Jan 03, 2015. In an interview with inspector, s-#107 stated they commenced the program on January 05, 2015, and would complete the program in August 2015, and had only completed one of five IPAC Core Competencies Courses through Public Health Ontario dated May 2014. The inspector contacted the post secondary college and was informed the Infection Control Practitioner Program duration was as follows: January 06 – July 29, 2015.

Review of the home's Resident Quality Inspection Report Plan of Correction dated November 17, 2014, stated that the most responsible person who the task was assigned to was s-#107 and the DOPCSN who would register for an infection control course that meets the specifications of O. Reg 79/10, s.229 (3) with a deadline of January 05, 2015.

Given that the order was to be complied with by January 05, 2015, the licensee has failed to ensure s-#107 obtained education and experience in infection prevention and control practices including, (a) infectious disease; (b) cleaning and disinfection; (c) data collection and trend analysis; (d) reporting protocols; and (e) outbreak management by January 05, 2015. [s. 229. (3)]

Additional Required Actions:

CO # - 002, 003 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. 113. Evaluation
Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee has failed to ensure that once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is done in accordance with the Act and this Regulation.

The inspector reviewed the home's Least Restraints Policy #LTC 130 VII-230 last reviewed date of June 24, 2010. In an interview with the inspector, the DOPCSN stated the policy has not been evaluated since 2010. [s. 113. (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation, to be implemented voluntarily.

Issued on this 4th day of August, 2015

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) : MONIKA GRAY (594)

Inspection No. / No de l'inspection : 2015_376594_0014

Log No. / Registre no: S-000519-14, S-000520-14, S-000521-14, S-000522-14

Type of Inspection / Genre d'inspection: Follow up

Report Date(s) / Date(s) du Rapport : Jul 24, 2015

Licensee / Titulaire de permis : LADY DUNN HEALTH CENTRE
17 Government Road, Box 179, Wawa, ON, P0S-1K0

LTC Home / Foyer de SLD : LADY DUNN HEALTH CENTRE
17 Government Road, P.O. Box 179, Wawa, ON, P0S-1K0

Name of Administrator / Nom de l'administratrice ou de l'administrateur : SALLY GARLAND

To LADY DUNN HEALTH CENTRE, you are hereby required to comply with the following order(s) by the date(s) set out below:

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: 2014_339579_0013, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device.
2. What alternatives were considered and why those alternatives were inappropriate.
3. The person who made the order, what device was ordered, and any instructions relating to the order.
4. Consent.
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Order / Ordre :

The licensee shall ensure that for resident #003, #004 and any other resident being restrained by a physical device under section 31 of the Act that the following are documented: The person who applied the device and the time of application, all assessment, reassessment and monitoring, including the resident's response.

Grounds / Motifs :

1. The licensee has failed to ensure that every use of a physical device to restrain a resident is documented including the person who applied the device and the time of application.

A Compliance Order was issued on November 05, 2014, during inspection

2014_339579_0013 with a compliance date of November 28, 2014; ordering the licensee to ensure that for resident #003, #004 and #005 that every use of a physical device to restrain a resident is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented: the person who applied the device and the time of application.

On June 03, 2015, the inspector observed resident #003 over the course of the day with various restraints used at various times. On June 04, 2015, the inspector reviewed the resident Restraint Record which failed to document any restraint use from 0100 hours until 1900 hours.

On June 03, 2015, the inspector observed resident #004 over the course of the day with a restraint in use. On June 04, 2015, the inspector reviewed the resident Restraint Record which failed to document any restraint use from 0700 until 1900.

The inspector reviewed resident #003 and #004 restraint records for the month of May/June and for resident #005 for the month of January/February 2015 and noted various dates and times which failed to document any restraint use.

In an interview with the inspector, the DOPCSN and s#-105 stated that it is the home's expectation that staff complete documentation before the end of their shift and verified that restraint documentation from June 03 for the resident #003 and #004 had not been completed.

The Least Restraints Policy #LTC 130 VII-230 reviewed by the inspector, stated that documenting the use of restraints and PASDs the following forms shall be used: nurses notes, care plans, Consent form for Restraints, restraint assessment/physician order, restraint record and individual restraint re-assessment form. According to the same document, if a restraint renders a resident incapable of moving or repositioning themselves, the resident shall be monitored and repositioned by a member of the nursing or personal care staff. This monitoring shall be done hourly, documentation of use of restraints and checks will be done on the flow sheet. (594)

2. The licensee has failed to ensure that every use of a physical device to restrain a resident is documented including all assessment, reassessment and monitoring, including the resident's response.

The inspector reviewed the restraint records for resident #003 and #004 for the month of May and part of June 2015; and resident #005 for the month of January and part of February 2015. Based on this documentation, the record indicated that nursing initials are required every 8 hours and code either "N" for necessary or "NR" for no longer required; as well as documentation identifying if the restraint was applied, released, visually checked; the restraint type and the resident's response to that restraint. The inspector noted:
- For resident #003 that on May 01 - 03, 06, 07, 09 -14, 18, 19, and 23 – 28, 2015, documentation failed to identify that the resident was reassessed and that the effectiveness of the restraining evaluated at least every eight hours, and at any other time based on the resident's condition or circumstances; and that on May 01, 11, 18, 19 and June 03, 2015, there were periods of time the lack of documentation failed to identify that a restraint was removed or reapplied and the resident's response, if required.
- For resident #004 that on May 04 – 06, 10 – 12, 19, 21 and 23-28, 2015, documentation failed to identify that the resident was reassessed and that the effectiveness of the restraining evaluated at least every eight hours, and at any other time based on the resident's condition or circumstances; and that on May 16-19, 29-30 and June 03, 2015, there were periods of time the lack of documentation failed to identify that a restraint was removed or reapplied and the resident's response, if required.
- For resident #005 that on January 04, 06, 08, 14, 15, 17 – 19, 21, 23, 24, 26 and 28, 2015, documentation failed to identify that the resident was reassessed and that the effectiveness of the restraining evaluated at least every eight hours, and at any other time based on the resident's condition or circumstances; and that on January 05, 16, 19, 23 and February 03, 2015, there were periods of time the lack of documentation failed to identify that a restraint was removed or reapplied and the resident's response, if required.

In an interview with the inspector, s#-100 stated the home's expectation is to document the effectiveness every eight hours. S#-100, s#-101 and s#103 all stated to the inspector that restraint documentation is to be completed on the restraint record.

The inspector reviewed the home's Restraint Record Audits completed during December 2014 and January 2015. According to these audits there was a pattern of failing to document assessment by an RN/RPN every eight hours; repositioning/checking (if the restraint was applied, released, visually checked, repositioned), resident response and reason for restraint.

The inspector interviewed the DOPCSN and s#-105 who confirmed that for resident #003, #004 and #005 there lacked documentation on the type of restraint applied and by whom, the resident's response and assessment by an RN/RPN. (594)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 17, 2015

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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 : 002

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

Linked to Existing Order / Lien vers ordre existant: 2014_339579_0013, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (2) The licensee shall ensure,
(a) that there is an interdisciplinary team approach in the co-ordination and implementation of the program;
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly;
(c) that the local medical officer of health is invited to the meetings;
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(e) that a written record is kept relating to each evaluation under clause (d) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 229 (2).

Order / Ordre :

The licensee shall ensure that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly and that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Grounds / Motifs :

1. The licensee has failed to ensure that the Infection Prevention and Control (IPAC) interdisciplinary team meet at least quarterly.

A Compliance Order was issued on November 05, 2014, during inspection 2014_339579_0013 with a compliance date of November 28, 2014; ordering the licensee to ensure that there is an interdisciplinary team that co-ordinates and implements the program and meets at least quarterly.

The inspector reviewed the IPAC Committee Meeting Minutes of 2014 – June

2015. Meetings were held on August 14, 2014; February 11 and May 20, 2015, with no date set for the next meeting.

The DOPCSN stated to the inspector in an interview, that the IPAC committee aims to hold meetings every month but at minimum occur quarterly. In an interview with the inspector, s#-107 stated meetings are held quarterly and the next meeting is scheduled for August with no specific date identified.

Review of the home's Resident Quality Inspection Report Plan of Correction dated November 17, 2014, stated that the most responsible person who the task was assigned to was s-#107 who would incorporate having at least 4 IPAC meetings per year, in the terms of reference with a deadline of November 19, 2014.

Given the licensee had a IPAC meeting in August of 2014, the compliance order was to be complied with by November 28, 2014, and the next IPAC meeting was not held until February 2015, the licensee has failed to ensure that the IAPC interdisciplinary team met at least quarterly. (594)

2. The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Program is evaluated and updated at least annually in accordance with evidence-based practices.

A Compliance Order was issued on November 05, 2014 during inspection 2014_339579_0013 with a compliance date of November 28, 2014; ordering the licensee to ensure that the infection prevention and control program was evaluated and updated at least annually in accordance with evidence based practices.

The inspector requested the IPAC Program evaluation from the DOPCSN who stated to the inspector that the program is scheduled to be evaluated at the next IPAC meeting.

Review of the home's Resident Quality Inspection Report Plan of Correction dated November 17, 2014, stated that the most responsible person who the task was assigned to was s-#107, who would establish time and date of next meeting of the Infection Control Committee to review the program annually and the deadline was to disseminate the necessary materials to review at next Infection prevention and control meeting on November 28, 2014.

Given that the licensee failed to comply with their own Plan of Correction and that no evaluation had been completed, the licensee failed to ensure that the infection prevention and control program was evaluated and updated at least annually in accordance with evidence based practices. (594)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 01, 2015

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2014_339579_0013, CO #004;

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 shall ensure that the designated staff member who co-ordinates the Infection Prevention and Control program has completed 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

Grounds / Motifs :

1. The licensee has failed to ensure that there is a designated staff member to co-ordinate the infection prevention and control (IPAC) program with education and experience in infection prevention and control practices.

A Compliance Order was issued on November 05, 2014, during inspection 2014_339579_0013 with a compliance date of January 05, 2015, ordering the licensee to ensure that the designated staff member who coordinated the Infection Prevention and Control Program obtained education and experience in infection prevention and control practices including, (a) infectious disease; (b) cleaning and disinfection; (c) data collection and trend analysis; (d) reporting protocols; and (e) outbreak management.

The inspector interviewed the DOPCSN who stated s-#107 was registered with a post secondary college in the Infection Control Practitioner Program that started on Jan 03, 2015. In an interview with inspector, s-#107 stated they commenced the program on January 05, 2015, and would complete the program in August 2015, and had only completed one of five IPAC Core Competencies Courses through Public Health Ontario dated May 2014. The inspector contacted the post secondary college and was informed the Infection Control Practitioner Program duration was as follows: January 06 – July 29, 2015.

Review of the home's Resident Quality Inspection Report Plan of Correction dated November 17, 2014 stated that the most responsible person who the task was assigned to was s-#107 and the DOPCSN who would register for an infection control course that meets the specifications of O. Reg 79/10, s.229 (3) with a deadline of January 05, 2015.

Given that the order was to be complied with by January 05, 2015, the licensee has failed to ensure s-#107 obtained education and experience in infection prevention and control practices including, (a) infectious disease; (b) cleaning and disinfection; (c) data collection and trend analysis; (d) reporting protocols; and (e) outbreak management by January 05, 2015. (594)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2015

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 24th day of July, 2015

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Monika Gray

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