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
Jan 23, 2015	2015_178102_0003	O-001404-14	Complaint

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 BERRY (102)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 15 and 16, 2015

During the inspection, policies and procedures related to the infection prevention and control program were reviewed. Outbreak surveillance records, 2014 PAC meeting minutes, a Ministry of Labour report with a visit date of December 04, 2014, and reprocessing product labels and practices were also reviewed. The home was toured.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Environmental Services Manager, nursing and program staff, several residents.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Infection Prevention and Control
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 VPC(s)**
- **1 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. At the time of inspection on January 15 and 16, 2015, "PCS5000" was the product

identified by management staff as being used to sterilize re-usable, critical, resident care equipment including: wound care supplies such as non disposable forceps and scissors; foot care instruments used by nursing staff: toe nail clippers, nippers. During the inspection, a partially used jug of the PCS5000 was located within the medication room. Written on the jug in marker pen: "footcare instrument sterilization". The manufacturer's label on the jug identified the contents as a "Disinfectant/cleaner", "0.5% sodium hypochlorite", "surface disinfectant for use on hard, non porous surfaces", expiry date August 3, 2014. It was identified by one management staff member that this product was chosen to "sterilize" equipment on the advice of a nurse who provides private pay foot care services to residents in the home. Several members of the nursing staff identified that a product called "Gamut" is used to disinfect the instruments, not PCS5000. It was also identified by staff that an autoclave is no longer available within the home to sterilize instruments.

A Registered Nurse on duty at the time of inspection identified that if she needs to obtain toe nail clippers to cut residents' toenails,the clippers are obtained from the tubroom.

On January 16, 2015 unlabelled large and small sized nail clippers and nippers were observed to be stored on shelves within both tubrooms. In the tubroom in the secure resident home area, visibly soiled nail clippers were present with other re-usable unlabelled nail care equipment. All of the nail care equipment was located on a small towel (face cloth) that was visibly soiled with nail clippings. Used unlabelled combs and a hair brush were also present on the same shelf, adjacent to the bath tub. Nail clippers and combs were observed within the other tubroom. A staff member identified that the nail clippers and combs are shared use, and are soaked in the "Gamut" solution after each use on a resident. The staff member identified that the nail clippers and combs are not cleaned prior to immersion in the disinfecting solution, which was identified to be changed daily.

The Gamut solution product label identifies the product as "Gamut Plus";that it is for disinfecting non-critical instruments/devices; is not to be used as a terminal disinfectant or high level disinfectant; critical and semi critical devices must be followed by an appropriate terminal sterilization or high level disinfection process.

Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment and Devices in All Health Care Settings, 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 includes foot care instruments and any instruments that enter sterile tissues, including the vascular system. These items present a high risk of infection if the equipment/device is contaminated with any microorganism, including bacterial spores. Reprocessing critical equipment/devices involves meticulous cleaning followed by sterilization. Semi critical equipment/devices includes shared use nail clippers. Reprocessing semicritical equipment/devices involves meticulous cleaning followed by, at a minimum, high-level disinfection.

Measures are not in place for the cleaning, disinfection or sterilization of re-usable and/or shared resident equipment which poses a potential cross infection risk to residents.

2. Resident care equipment is stored within the centrally located soiled utility room. On January 16, 2015 commodes were observed stored in close proximity to both sides of the hopper/flusher, which has an operational sprayer attached. The equipment is exposed to cross contamination from splashing and/or aerosol from the use of the hopper.

3. At the time of the inspection on January 16, 2015 paints and painting supplies were observed to be stored on the floor in the central soiled utility room. Workers involved with painting within the building were observed entering and exiting the soiled utility room. The soiled utility room is a contaminated area and as such, the use of the room to store building supplies and have maintenance workers retrieving supplies increases the risk of cross contaminating surfaces in the long term care home.

4. At the time of this inspection, the Director of Care was identified as the staff member designated to co-ordinate the infection prevention and control program. The Director of Care identified that she does not have education and experience in infection prevention and control practices including cleaning and disinfection; data collection and trend analysis; reporting protocols and outbreak management as is required by O. Reg. 229/10, s. 229. (3).

The licensee has failed to ensure that the infection prevention and control program includes measures to prevent the transmission of infections which is a potential risk to the health, comfort and safety of residents.

On November 14, 2014 an enteric outbreak was declared by the local public health unit. Outbreak # 2238-2014-044 was assigned. The outbreak was declared over on December December 03, 2014. 50 residents and 39 staff members were identified to have been infected. The outbreak of a reportable communicable disease was not reported to the

Director as per O. Reg. 79/10, s. 107. [s. 86. (2) (b)]

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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan for responding to infectious disease outbreaks is complied with, increasing the potential risks to the health, comfort, safety and well being of residents.

The Hallowell House Outbreak and Infection Control Manual contains a 3 page "Outbreak Contingency Plan". The plan identifies that the Director of Care or designate will take a number of actions,including notification to the Ministry of Health of a suspected or actual outbreak; will call an outbreak management team meeting, etc. The core membership of the Outbreak Management Team is identified on page 3 of the plan and includes all managers, staff member of the Health and safety committee, other staff all departments. The plan identifies that the outbreak management team will meet within 24 hours of an outbreak, record minutes of meeting, etc. The plan also identifies actions to be taken once the outbreak is declared over, including analyze and identify possible factors responsible and problems experienced, etc.

Outbreak Roles and Responsibilities for staff are identified in a labeled binder. A comprehensive checklist is provided for Management staff and staff of each department.

On November 14, 2014 an enteric outbreak affecting residents in Hallowell House was declared by the local Public Health Unit. Outbreak # 2238-2014-044 was assigned. The Ministry of Health and Long Term Care was not informed of this outbreak.

It was identified that the Outbreak Management Team, as identified in the Outbreak Contingency Plan, did not meet during the outbreak or once the outbreak was declared over. [s. 8. (1)]

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 the home's written Outbreak Contingency Plan, including staff roles and responsibilities, are in compliance with applicable requirements under the Act, and are complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are implemented to ensure that the temperature of the water serving all bath tubs, showers and hand basins used by residents is 49 degrees Celsius or less and is controlled by a device that regulates the temperature.

The "Water temperature chart" located in the water temperature binder at the nurses station identifies that for all shifts on January 10 and 11 and the night shift on January 14, 2015 the water temperature in resident areas was above 49 degrees Celsius.

During the inspection on January 16, 2015, at 1:45 pm, the water temperature briefly peaked at 54 degrees Celsius, dropped to 30 degrees Celsius,and then leveled out at 42 degrees Celsius at a resident's sink located in an ensuite washroom across from the Nursing office. [s. 90. (2) (g)]

2. The licensee has failed to ensure that the water temperature is monitored once per shift in random locations where residents have access to hot water.

Management staff of the home confirmed that staff are to check and record the

temperature of hot water serving resident areas once per shift. The water temperature is to be recorded on a sheet labelled "water temperature chart", located in the Water Temperature binder at the main nurses station.

Records for November 2014, December 2014 and January 2015 were reviewed. Water temperatures were not entered on the sheets for the majority of shifts during the 3 month period that was reviewed.

It was noted that water temperatures above 49 degrees Celsius were recorded by staff on lines indicating January 10 and 11 (the "13th" was written in next to the location). A temperature of "54.0 then 46.7 with 2 minute run" was identified on Jan 14, night shift.

During the inspection on January 16, the inspector checked the water temperature at approximately 1:30 pm in the unlocked visitor washroom adjacent to the Nursing Office and hair salon. The water temperature briefly reached 52 degrees Celsius and then remained at 42 degrees Celsius.

The hot water temperature records and temperature spike noted was brought to the attention of the Administrator and the Environmental Services Manager prior to completing the on site inspection on January 16, 2015. [s. 90. (2) (k)]

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 the temperature of hot water does not exceed 49 degrees Celsius at any time at any resident sink, shower or bath tub and that staff check hot water temperature once per shift in resident areas and take immediate action when the hot water temperature is identified to be greater than 49 degrees Celsius, to be implemented voluntarily.

WN #4: 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,
(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. (2) The licensee shall ensure,
(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).

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) program is evaluated and updated at least annually in accordance with evidence base practices.

The Hallowell House Outbreak Contingency plan was identified as reviewed February 2013.
The binder identified as "Revera Infection Prevention and Control Policies and Procedures" is dated 2013. The Administrator and the Director of Care both identified that Revera policies are available online. The online policies and procedures were not reviewed during this inspection. Printed material provided in binders in the home was reviewed during the inspection on January 15 and 16, 2015.

PIDAC Best Practices documents are the evidence based and prevailing practices in Ontario. The home's IPAC program must also include surveillance protocols given by the Director under s. 229(7). [s. 229. (2) (d)]

2. The licensee has failed to ensure that a written record is kept of past evaluations of the infection prevention and control program including names of persons who participated, summary of changes made and the date any changes were implemented. [s. 229. (2) (e)]

3. The licensee has failed to ensure that the designated staff member that co-ordinates the infection prevention and control program has education and experience in required infection prevention and control practices.

During the inspection conducted on January 15, 2015 the Director of Care identified that she is the designated staff member that co-ordinates the infection prevention and control program in the home.

The Director of Care was asked if she has training and experience in each of the listed infection prevention and control practices, which includes: infectious disease, cleaning and disinfection, data collection and trend analysis, reporting protocols and outbreak management. The response was "no", other than participation in non specified public health educational workshops and online courses. [s. 229. (3)]

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 update the infection prevention and control program annually and to ensure that the staff member responsible for coordinating the program has the required education and experience, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):

1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).

2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).

4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).

5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:

1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.

O. Reg. 79/10, s. 107 (4).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 107 (4).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. for incidents involving a resident, whether a family member, person of importance or a substitute decision-maker of the resident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
O. Reg. 79/10, s. 107 (4).

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is informed immediately of an outbreak of a reportable disease or communicable disease as defined in the Health Promotion and Protection Act.

On November 14, 2014 an enteric outbreak affecting residents in Hallowell House was declared by the local Public Health Unit. Outbreak # 2238-2014-044 was assigned. The Ministry of Health and Long Term Care was not informed of this outbreak. As of the date of inspection on January 15 and 16, 2015 the outbreak had still not been reported. [s. 107. (1)]

2. The licensee has failed to ensure that a report in writing was made to the Director within 10 days of becoming aware of the enteric outbreak. [s. 107. (4) 1.]

3. A description of the outbreak has not been provided. [s. 107. (4) 2.]

4. The licensee has failed to ensure that required details of the enteric outbreak are reported. [s. 107. (4) 3.]

5. The licensee has failed to ensure that a written report which includes analysis and follow up actions is provided of the enteric outbreak. [s. 107. (4) 4.]

Issued on this 23rd day of January, 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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	WENDY BERRY (102)
Inspection No. / No de l'inspection :	2015_178102_0003
Log No. / Registre no:	O-001404-14
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 23, 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:

Order # / Ordre no : 001

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

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 will prepare, submit and implement a plan for achieving compliance to ensure that the infection prevention and control program includes measures to prevent the transmission of infections:
1. a qualified staff member who has education and experience in infection prevention and control practices as required by O.reg. 79/10, s. 229(3) is to be designated to co-ordinate the program;
2. policies that are in accordance with evidence-based best practices for the cleaning, disinfection and sterilization of all resident care equipment are to be implemented immediately;
3. staff who are involved in the reprocessing of shared or reusable resident care equipment are to be trained on the policies, including the correct use of any chemicals or equipment as per manufacturers' directions, which must be identified for products in use;
4. resident care equipment and supplies are to be appropriately stored so as to be protected from cross contamination.

The plan of action, which includes compliance dates and corrective actions taken and planned, is to be submitted by February 16, 2015 to the attention of Wendy Berry, Long Term Care Homes Inspector; fax # 613 569 9670.

Grounds / Motifs :

1. At the time of inspection on January 15 and 16, 2015, "PCS5000" was the product identified by management staff as being used to sterilize re-usable, critical, resident care equipment including: wound care supplies such as non

disposable forceps and scissors; foot care instruments used by nursing staff: toe nail clippers, nippers. During the inspection, a partially used jug of the PCS5000 was located within the medication room. Written on the jug in marker pen: "footcare instrument sterilization". The manufacturer's label on the jug identified the contents as a "Disinfectant/cleaner", "0.5% sodium hypochlorite", "surface disinfectant for use on hard, non porous surfaces", expiry date August 3, 2014. It was identified by one management staff member that this product was chosen to "sterilize" equipment on the advice of a nurse who provides private pay foot care services to residents in the home. Several members of the nursing staff identified that a product called "Gamut" is used to disinfect the instruments, not PCS5000. It was also identified by staff that an autoclave is no longer available within the home to sterilize instruments.

A Registered Nurse on duty at the time of inspection identified that if she needs to obtain toe nail clippers to cut residents' toenails,the clippers are obtained from the tubroom.

On January 16, 2015 unlabelled large and small sized nail clippers and nippers were observed to be stored on shelves within both tubrooms. In the tubroom in the secure resident home area, visibly soiled nail clippers were present with other re-usable unlabelled nail care equipment. All of the nail care equipment was located on a small towel (face cloth) that was visibly soiled with nail clippings. Used unlabelled combs and a hair brush were also present on the same shelf, adjacent to the bath tub. Nail clippers and combs were observed within the other tubroom. A staff member identified that the nail clippers and combs are shared use, and are soaked in the "Gamut" solution after each use on a resident. The staff member identified that the nail clippers and combs are not cleaned prior to immersion in the disinfecting solution, which was identified to be changed daily.

The Gamut solution product label identifies the product as "Gamut Plus";that it is for disinfecting non-critical instruments/devices; is not to be used as a terminal disinfectant or high level disinfectant; critical and semi critical devices must be followed by an appropriate terminal sterilization or high level disinfection process.

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in Ontario for the reprocessing of shared and/or re-usable resident care equipment. Critical equipment/devices includes foot care instruments and any instruments that enter sterile tissues, including the vascular system. These items present a high risk of infection if the equipment/device is contaminated with any microorganism, including bacterial spores. Reprocessing critical equipment/devices involves meticulous cleaning followed by sterilization. Semi critical equipment/devices includes shared use nail clippers. Reprocessing semicritical equipment/devices involves meticulous cleaning followed by, at a minimum, high-level disinfection.

Measures are not in place for the cleaning, disinfection or sterilization of re-usable and/or shared resident equipment which poses a potential cross infection risk to residents.

2. Resident care equipment is stored within the centrally located soiled utility room. On January 16, 2015 commodes were observed stored in close proximity to both sides of the hopper/flusher, which has an operational sprayer attached. The equipment is exposed to cross contamination from splashing and/or aerosol from the use of the hopper.

3. At the time of the inspection on January 16, 2015 paints and painting supplies were observed to be stored on the floor in the central soiled utility room. Workers involved with painting within the building were observed entering and exiting the soiled utility room. The soiled utility room is a contaminated area and as such, the use of the room to store building supplies and have maintenance workers retrieving supplies increases the risk of cross contaminating surfaces in the long term care home.

4. At the time of this inspection, the Director of Care was identified as the staff member designated to co-ordinate the infection prevention and control program. The Director of Care identified that she does not have education and experience in infection prevention and control practices including cleaning and disinfection; data collection and trend analysis; reporting protocols and outbreak management as is required by O. Reg. 229/10, s. 229. (3).

The licensee has failed to ensure that the infection prevention and control program includes measures to prevent the transmission of infections which is a potential risk to the health, comfort and safety of residents.

On November 14, 2014 an enteric outbreak was declared by the local public health unit. Outbreak # 2238-2014-044 was assigned. The outbreak was declared over on December December 03, 2014. 50 residents and 39 staff members were identified to have been infected. The outbreak of a reportable communicable disease was not reported to the Director as per O. Reg. 79/10, s. 107. (102)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 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 23rd day of January, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : WENDY BERRY

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