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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 26, 2016	2016_280541_0026	013559-16	Resident Quality Inspection

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

WEST LAKE TERRACE
1673 COUNTY ROAD, 12 R. R. #1 PICTON ON K0K 2T0

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

AMBER LAM (541), DARLENE MURPHY (103)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 19-22, 2016

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Nutritional Care Manager/Environmental Manager, the Life Enrichment Coordinator, the Registered Dietitian, Registered Nurses, Registered Practical Nurses, Personal Support Workers/Health Care Aides, Housekeepers, Laundry staff, the President of the Resident Council, Residents and Families. In addition, the inspectors conducted a tour of the home, reviewed resident health care records, observed a medication administration and reviewed relevant policies and procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **9 WN(s)**
- **4 VPC(s)**
- **2 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

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 saillants :

1. The licensee has failed to ensure that the staff member designated to co-ordinate the infection prevention and control program has education and experience in the areas specified by the legislation.

The Director of Care (DOC) was identified by the Administrator as the designated lead of the infection prevention and control program in the home. The DOC was interviewed in regards to the home's infection control practices and indicated she had attended many one day education sessions related to infection prevention and control that are offered through the public health unit. Inspector #103 asked the DOC if she had received education and experience in infection prevention and control that included infectious diseases, cleaning/disinfection, data collection/trend analysis, reporting protocols and outbreak management. The DOC stated she felt she had some experience in these areas but had not received formal education in all the required areas. [s. 229. (3)]

2. The licensee has failed to ensure all staff participate in the implementation of the infection control program.

On September 19, 2016, PSW #107 was observed entering a specified room with an open commode bucket that appeared to contain urine and stool. The PSW stated to this inspector that she was sorry, but she had to dispose of this mess and proceeded to add water to the bucket from the resident sink and then dump the contents into the toilet. The PSW was observed to leave the bathroom in the specified room, returned to another

specified room to replace the commode bucket in the commode located next to resident #009's bed and then indicated to another staff member that she would assist her in getting a resident up for lunch. The PSW entered a third specified room and at no time was observed hand sanitizing. PSW #107 was interviewed later that day and was able to identify that two resident's in the specified room from which the dirty commode was removed, were on contact precautions, one of which was resident #009.

The DOC was identified as the lead for the infection control program and was interviewed. She indicated she wasn't sure if the staff were aware of resident #009's newly diagnosed infection on September 19, 2016. The DOC did state to avoid the spread of infection, using a co-resident bathroom's would not be an appropriate infection control practice and that hand sanitizing would be expected after completing care on a resident. [s. 229. (4)]

3. On September 19, 2016 Inspector #541 observed the bathroom in a specified room. There was an emesis basin in the bathroom with three unlabeled toothbrushes stored in it. The basin was not labeled. This bathroom is shared by 4 residents, one of which is on contact precautions.

The following unlabeled items were also noted during the inspection.

Room 101 - An unlabeled white urine hat was stored on the rack behind the toilet in a shared washroom.

Room 102 - An unlabeled urine basin was stored on the rack behind the toilet in a shared washroom. The basin was noted to be dirty.

Room 103 - Two unlabeled toothbrushes in a shared washroom.

Room 104 - An unlabeled urinal was stored on a rack behind the toilet in a shared washroom. There is a sign for contact precautions on the door to this room. [s. 229. (4)]

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. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented using at a minimum a low level disinfectant for the cleaning and disinfection of resident care equipment such as whirlpools, tubs, shower chairs and lift chairs.

During the initial tour of the home on September 19, 2016 and throughout the inspection period, inspector #103 observed a spray bottle labelled bathroom cleaner and de-scaler available in the home's tub/shower room. PSW #102 was interviewed in regards to the product used to clean and disinfect the tub, shower chairs and lift chairs. The PSW confirmed the spray bottle, labelled "Crew-bathroom cleaner and de-scaler" was the product used and that it is sprayed onto the empty tub, allowed to sit for several minutes and then scrubbed with a bristle brush and rinsed.

The DOC was identified as the lead for the infection control program and was interviewed. She consulted with the Administrator who confirmed the use of the above noted product for the cleaning and disinfection of the resident tub, shower chairs and lift chairs. The product was researched and it was determined the product does not meet the legislated requirement that it must be, at a minimum, a low level disinfectant used in these areas. Disinfection of whirlpools, resident tubs, shower chairs and lift chairs are necessary to prevent the spread of infections between residents. The DOC indicated the home has existing residents diagnosed with Methicillin resistant Staphylococcus aureus (MRSA) and have recently had two additional resident's, #009 and #021, diagnosed with MRSA.

On September 22, 2016, the Administrator approached this inspector and indicated a new protocol was put into place for resident tubs, shower chairs and lift chairs following the above discussion. The Administrator indicated he had initiated the use of "Arjo Encore tub cleaner". The product was again researched by this inspector and does not meet the minimum requirements of a low level disinfectant. [s. 87. (2) (b)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that that the home is a safe and secure environment for its residents.

On September 19, 2016 during the initial tour of the home, Inspector #103 observed the steam table in the dining room to be turned on and hot water in the wells. There were seven residents in the dining room and no staff were present. The lids over the steam wells were so hot that inspector could not place hand on the lid for more than two seconds.

Over the course of the inspection, Inspector #103 and #541 observed the steam table to be left on with residents in the dining room and no staff supervision. Each time the steam table was noted to be too hot to touch the lids of the steam wells. The steam table was easily accessible to any resident who approached it. Residents are in the dining room at all times as it doubles as a resident activity area. [s. 5.]

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 is a safe and secure environment for its residents by ensuring the steam table is not accessible to residents when no staff are present,, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure resident #003's care was provided as specified in the plan.

On a specified date during the breakfast meal, inspector #103 observed resident #003 seated in a wheelchair with a lap tray in place. The resident's wheelchair was positioned between two resident dining tables such that staff feeding at the adjacent table would be unable to visually monitor the resident's intake. The resident was noted to have a small white bowl on the tray and was holding a spoon in his/her right hand. From 0900 hr until 0925 hr, resident #003 was observed to fall asleep intermittently. During this period of time, staff did not provide any physical feeding assistance to the resident. At 0925hr, the bowl was removed by a staff member and it was noted to still contain what appeared to be cereal.

Resident #003's current care plan was reviewed in regards to the level of assistance that is required during meals. The care plan indicated:
-staff will provide the necessary assistance to ensure that adequate nutrition/hydration is maintained
-resident requires extensive assistance when eating, 1 staff feeds when resident is incapable of feeding self.
-resident is often unable to feed self and must be totally fed by staff

The resident's care plan also indicated the resident was a high nutritional risk and over a two and a half month period had a demonstrated weight loss of seven kilograms.

PSW #106 was interviewed and indicated resident #003 does not like to be fed and is able to feed him/herself most of the time. PSW #105 was interviewed and indicated resident #003's condition has deteriorated and is rarely able to feed self. This PSW indicated she determines the resident's ability to feed him/herself by first offering the resident verbal cueing, and then assisting the resident to raise the spoon to his/her mouth. If these strategies are unsuccessful, the staff member indicated the resident is fed by staff.

The home's dietitian was interviewed and indicated she has noted a decline in the resident's overall condition over the past several months and that the resident prior to this had been able to eat more independently with cueing or minimal assistance from the staff. She indicated the resident has been ordered a supplement due to weight loss and stated it was her understanding the resident was receiving total assistance from the staff at each meal unless the resident was able to eat on their own. The dietitian indicated it

would be her expectation that staff are monitoring throughout the meal to ensure the resident is eating and to provide total feeding assistance when the resident is not capable of doing so. [s. 6. (7)]

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 care set out in the plan of care for resident #003 related to feeding assistance is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the PASD described in subsection (1) that is used to assist a resident with a routine activity of living is included in the resident's plan of care.

On September 22, 2016 resident #003 was observed by Inspector #541 in a wheelchair that was tilted and a lap tray applied. RN #103 confirmed during an interview that resident #003 is to have a table top and seat belt applied for safety while up in his/her wheelchair.

An assessment was completed for resident #003 on a specified date and indicates the resident is to have a lap belt, tilt wheelchair and a lap tray applied.

Resident #003's plan of care was reviewed and indicates the resident is to have a table top for safety while up in wheelchair. There is no indication in the resident's plan of care he/she is to have a tilt wheelchair. [s. 33. (3)]

2. Resident #011 was observed by Inspector #541 in a tilt wheelchair with a lap tray applied on two specified dates.
A PASD (Personal Assistive Supportive Device) assessment was completed by RN #103 on a specified date. According to this assessment, resident #011's tilt wheelchair and lap tray are considered PASDs.

RN #103 confirmed during an interview with Inspector #541 that resident #011 is to have a lap tray and tilt wheelchair in use for positioning.

Resident #011's current plan of care indicates that resident #011 is to have a lap belt applied for safety. There is no indication in resident #011's plan of care the resident is to have a PASD of a tilt wheelchair or lap tray.

The licensee failed to ensure that the PASDs in use for resident #003 and #011 are included in the residents' plans of care. [s. 33. (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 ensure that a PASD described in subsection (1) is used to assist resident #003 and #011 with a routine activity of living only if the use of the PASD is included in the resident's plan of care, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 114 (3).
(b) reviewed and approved by the Director of Nursing and Personal Care and the pharmacy service provider and, where appropriate, the Medical Director. O. Reg. 79/10, s. 114 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that policies related to expired medications were implemented.

On September 20, 2016, this inspector conducted a review of the home's stock medication cupboard and the home's medication administration cart.

During a review of the stock medication cupboard, 10 bottles of Milk of Magnesia were found with an expiry date of July 2016, 2 bottles with an expiry date of May 2016, 1 bottle with an expiry date of August 2015, and 2 bottles with an expiry date of February 2015. Additionally 1 bottle of Dimenhydrinate was found with an expiry date of December 2015. The cupboard had evidence of old stock at the back and newer stock at the front.

During a review of the medication cart, the inspector found 1 bottle of Colace that was opened and expired on August 2016.

RN #103 indicated staff are required on the night shift to check for expired medications weekly and that last week's check found no expired medications. The home's policy on "Drug Destruction and Disposal", #5.4, indicates under procedure to identify on an ongoing basis any medication for disposal including expired goods. [s. 114. (3) (a)]

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 written policies and protocols are, (a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee failed to ensure the restraint by a physical device is included in the plan of care.

On a specified date resident #003 was observed by Inspector #541 in a wheelchair that was tilted and a lap tray applied. RN #103 confirmed during an interview that resident #003 is to have a table top PASD and seat belt applied for safety due to a history of falls. RN #103 further stated resident #003 is unable to follow directions to undo the seat belt. Inspector #541 also confirmed resident #003 is unable to undo the seat belt.

A physical restraint Resident Assessment Protocol (RAP) was completed on a specified date and indicates resident #003 is to have a 10 lb front closure lap belt applied for safety due to a history of falls.

Resident #003's plan of care was reviewed and indicates the resident is to have a table top as a PASD while up in wheelchair. There is no indication in the resident's plan of care that he/she is to have seat belt restraint applied.

The licensee failed to ensure that the seat belt restraint for resident #003 is included in the plan of care. [s. 31. (1)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to provide a response in writing within 10 days of receiving Resident Council advice related to concerns or recommendation.

The Resident Council meeting minutes were reviewed for June to September 2016. A meeting was held on June 6, 2016. The council raised concerns regarding the change to the bath schedule and questioned why residents of the same sex cannot use the tub/shower room at the same time. The council brought forward feeling rushed when they are being showered and if a tub bath is requested it is not provided. The council further questioned having an additional PSW during the day to help.

There was no written response provided to this concern regarding resident baths. LEC staff member #100 is the assistant to the council. When asked the process for receiving responses to concerns raised at the resident council meeting, LEC staff #100 states she forwards the responses to the appropriate manager/department and waits for their response. LEC #100 further stated she does not consistently receive responses back. Inspector #541 asked if the concern mentioned above was provided to the nursing department, LEC staff #100 stated it was but no response was provided in return. [s. 57. (2)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs are stored are kept locked at all times when not in use.

On September 21, 2016, inspector #103 observed the door to the medication room, located directly behind the nursing station, propped open. The inspector entered the medication room and found no registered staff in the room or in the vicinity. This medication room is the main storage area for stock medications and emergency drugs. Both the RPN and the RN were observed to be located in the entrance way of the dining room administering medications.

The inspector continued to monitor the medication door which was not within sight of either registered staff for a period of twenty minutes. During this time several residents were observed near the nursing desk as well as one visitor. The inspector informed the RPN and the RN that the medication door had been left open and RPN #101 responded that she believed she had "kicked the door shut" when she left the room.

The home failed to ensure all areas where drugs are stored was kept locked when not in use. [s. 130. 1.]

Issued on this 29th day of September, 2016

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMBER LAM (541), DARLENE MURPHY (103)
Inspection No. / No de l'inspection :	2016_280541_0026
Log No. / Registre no:	013559-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Sep 26, 2016
Licensee / Titulaire de permis :	Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner 2020 Fisher Drive, Suite 1, PETERBOROUGH, ON, K9J-6X6
LTC Home / Foyer de SLD :	WEST LAKE TERRACE 1673 COUNTY ROAD, 12, R. R. #1, PICTON, ON, K0K-2T0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Neil Peterson

To Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner, 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) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

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

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

Grounds / Motifs :

1. The licensee has failed to ensure that the staff member designated to co-ordinate the infection prevention and control program has education and experience in the areas specified by the legislation.

The Director of Care (DOC) was identified by the Administrator as the designated lead of the infection prevention and control program in the home. The DOC was interviewed in regards to the home's infection control practices and indicated she had attended many one day education sessions related to infection prevention and control that are offered through the public health unit.

Inspector #103 asked the DOC if she had received education and experience in infection prevention and control that included infectious diseases, cleaning/disinfection, data collection/trend analysis, reporting protocols and outbreak management. The DOC stated she felt she has had some experience in these areas but has not received formal education in all the required areas.

The decision to issue a Compliance Order (CO) was made based on the fact that the scope of the non-compliance was determined to be widespread as all residents in the home are affected by infection control practices and there is a potential for harm. (103)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 29, 2017

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,

(a) cleaning of the home, including,

(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and

(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and

(iii) contact surfaces;

(c) removal and safe disposal of dry and wet garbage; and

(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Order / Ordre :

The licensee is ordered to ensure the cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence based practices and, if there are none, in accordance with prevailing practices:

- Resident care equipment, such as whirlpools, tubs, showers, and lift chairs.

Grounds / Motifs :

1. The licensee has failed to ensure that procedures are developed and implemented using at a minimum a low level disinfectant for the cleaning and disinfection of resident care equipment such as whirlpools, tubs, shower chairs and lift chairs.

During the initial tour of the home on September 19, 2016 and throughout the inspection period, inspector #103 observed a spray bottle labelled bathroom cleaner and de-scaler available in the home's tub/shower room. PSW #102 was interviewed in regards to the product used to clean and disinfect the tub, shower chairs and lift chairs. The PSW confirmed the spray bottle, labelled "Crew-bathroom cleaner and de-scaler" was the product used and that it is sprayed onto the empty tub, allowed to sit for several minutes and then scrubbed with a bristle brush and rinsed.

The DOC was identified as the lead for the infection control program and was interviewed. She consulted with the Administrator who confirmed the use of the above noted product for the cleaning and disinfection of the resident tub, shower chairs and lift chairs. The product was researched and it was determined the product does not meet the legislated requirement that it must be, at a minimum, a low level disinfectant used in these areas. Disinfection of whirlpools, resident tubs, shower chairs and lift chairs are necessary to prevent the spread of infections between residents. The DOC indicated the home has existing residents diagnosed with Methicillin resistant Staphylococcus aureus (MRSA) and have recently had two additional resident's diagnosed with MRSA.

On September 22, 2016, the Administrator approached this inspector and indicated a new protocol was put into place for resident tubs, shower chairs and lift chairs following the above discussion. The Administrator indicated he had initiated the use of "Arjo Encore tub cleaner". The product was again researched by this inspector and does not meet the minimum requirements of a low level disinfectant.

The decision to issue a Compliance Order (CO) was based on the fact that the scope of the non-compliance was determined to be widespread and there is actual risk of harm to residents. (103)

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

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2016

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 26th day of September, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amber Lam

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