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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 5, 2017	2017_556168_0024	014632-17	Resident Quality Inspection

Licensee/Titulaire de permis

CITY OF HAMILTON
77 James Street North, Suite 400 HAMILTON ON L8R 2K3

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

WENTWORTH LODGE
41 SOUTH STREET WEST DUNDAS ON L9H 4C4

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

LISA VINK (168), THERESA MCMILLAN (526)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): July 17, 18, 19, 20 and 21, 2017.

During the course of this inspection the following Critical Incident intakes were inspected concurrently:
029666-16 - related to medication management system and reports regarding critical incidents
035308-16 - related to medication management system
004775-17 - related to prevention of abuse and neglect
007498-17 - related to medication management system
007921-17- related to prevention of abuse and neglect
016234-17 - related to prevention of abuse and neglect.

During the course of this inspection the following Critical Incident intakes were completed as inquiries:
027882-16 - related to falls prevention and management
011022-17 - related to prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with the acting Administrator, the acting Director of Nursing (ADOC), Nurse Managers, registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), the consultant pharmacist, Admissions - Volunteer Coordinator, office staff, environmental staff, family members and residents.

During the course of the inspection, the inspector(s) toured the home, observed the provision of care and services and reviewed relevant records including but not limited to: clinical health records, investigative notes, policies and procedures and incident reports.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

- **7 WN(s)**
- **5 VPC(s)**
- **0 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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that that there was a written plan of care for each resident that set out the planned care for the resident.

A. According to the Resident Assessment Instrument - Minimum Data Set (RAI MDS) completed in January 2017, resident #009 required extensive assistance from two staff for bed mobility.
The plan of care dated ten days later indicated that two persons were to provide extensive assistance with bed mobility, which was an intervention in place since 2016.
Internal investigative notes and a Critical Incident System (CIS) report from later in 2017, identified the resident reported that a PSW had provided them bed mobility, with one person, which caused pain in a specified area.
Review of the health record revealed that the resident received analgesia for pain at the time of the allegation.
According to the Nurse Manager, who investigated the incident, it was determined that the resident was able to assist with bed mobility and that one staff person completed this task for brief changes during the night. If the resident required additional assistance, two PSW staff would be required to provide care.
The Nurse Manager was not able to verify that staff actions caused the resident pain or injury on the identified date in 2017.
During interview PSW #108 reported that the resident could assist with turning and that only one staff provided some assistance with bed mobility.
Resident #009 confirmed that they could assist to turn and reposition while in bed, that one staff could assist them instead of two, and that they had chronic pain in the identified

area.
The Nurse Manager confirmed that the written plan of care did not set out the planned care in relation to bed mobility and the care that staff provided to the resident.

PLEASE NOTE: This area of non compliance was identified during a Critical Incident System (CIS) inspection log #004775-17, conducted concurrently during this Resident Quality Inspection.

B. Resident #002 was identified to have an area of altered skin integrity when observed. During a review of the clinical record it was identified that the resident had experienced ongoing concerns with their skin.
The resident had been reviewed by the registered nursing staff and the physician and had been referred to both the nurse practitioner and the pharmacist in an effort to manage the symptoms that they experienced.
The resident had orders for the application of a moisturizer and the administration of a medication.
A review of the plan of care did not include a focus statement related to the ongoing status of the resident's skin nor the planned care to manage the symptoms experienced, which was confirmed by RN #117 and RN #119, following a review of the clinical record. [s. 6. (1) (a)]

2. The licensee failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences.

Resident #003 reported to Inspector #526 that they felt staff rushed them, in the morning, during care and that this made the care feel rough. They reported that before they were fully awake, staff would initiate morning care and transfer them into their mobility device. The resident would then be required to wait two hours before breakfast. They resident said that they felt afraid to speak with anyone about staff rushing during care.
Review of health records revealed that night staff provided morning care on the days that were not the resident's bath days, and day staff provided morning care on bath days.
During interviews with PSW's #105, #107, #108 and RPN #106, it was stated that the resident would call early in the morning to use the bathroom and that was when care was provided.
PSW #107 said that the resident had mentioned that they felt rushed in the morning and that they had told registered staff including RPN #106.
RPN #106 confirmed that the night staff trying to finish care at the end of their shift may have been rushed.

Review of the resident's health records revealed that their preferences around sleep and rest and how to receive morning care was not assessed nor included in the written plan of care.
RPN #106 and the Admissions Coordinator stated that on admission, the Admissions Coordinator would review the Resident Assessment Inventory with the resident and family and that registered staff would review care needs and document these in the progress notes.
RPN #106 confirmed that an assessment of the resident's preferences in terms of sleep and rest and morning care were not found in the health record nor anything to indicate preferences in the plan of care in relation to these care areas. [s. 6. (2)]

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 written plan of care sets out the planned care for the resident, to be implemented voluntarily.

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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Ontario Regulation 79/10 section 114 requires the licensee to have written policies and

protocols developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration and destruction and disposal of all drugs used in the home.

The home had a policy for Medication Administration - Shift Change Controlled Substance Count, NM 10-00-36, review date November 2, 2016.
This policy identified a procedure that "two registered staff do the following: The oncoming registered staff is to complete the physical count of all controlled substances stored on that resident area in the presence of the outgoing registered staff. The outgoing registered staff documents the number of controlled substances confirmed by the incoming registered staff on the Combined Individual Monitored Medication Record with Shift Count form" and "two registered staff will complete the count at 0700 hours, 1500 hours and 2300 hours each day".
Critical incident report M592-000043-16 was reviewed.
This report identified that on a specified date in 2016, at 2300 hours, the narcotic count for medications ordered for resident #007 was completed and no discrepancies were identified.
The following day the count was not completed, at 0700 hours, as required, as the day RPN assigned to the resident area was late on their arrival to work, despite the fact that the home had a process in place to complete counts with another oncoming registered staff member as per the acting Administrator.
Night RPN #120 did not complete a shift change controlled substance count prior to leaving the home; however, was not available for interview, during this inspection.
At 0720 hours, a narcotic count was completed by two registered staff on the day shift, including RPN #125.
When documenting the results of the count on the Combined Individual Monitored Medication Record with Shift Count form it was identified that the narcotic count was not consistent with the documentation available and that one half tablet of a medication was missing.
Interview with RPN #125 confirmed that the count was not completed at shift change as requested on the identified date as was the expectation in the home.
An internal investigation into the missing medication was conducted and it was identified that staff did not comply with the home's procedure, for Medication Administration - Shift Change Controlled Substance Count, on the identified day, as confirmed by the acting Administrator.

PLEASE NOTE: This area of non compliance was identified during a Critical Incident System (CIS) inspection log 029666-16, conducted concurrently during this Resident

Quality Inspection. [s. 8. (1) (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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails were used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

It was identified that the home had a number of bed systems available. Some beds included assist rails, others had one third rails positioned at the upper portion of the bed or on the middle of the bed and others included a combination of one half and one quarter rails.
A Bed Rail Risk Assessment would be completed on all residents on admission and with a significant change in needs to determine the need for the rail(s) as identified by the

acting Administrator, ADOC and RPN #101.
A review of the Bed Rail Risk Assessment included assessment questions related to: did the resident have confusion, learning disability, agitation, unable to comprehend or were they distressed; did they have epilepsy or other involuntary movements, were they at risk of climbing over the rails; did they have altered sensation and did they need to get out of bed unsupervised.
The assessment also included clinical decision making questions regarding: were the rails requested by the resident and/or substitute decision maker and if so the rationale for the request; if the bed rails prevented the resident from getting out if bed, and if yes to ensure that the restraint policy and procedure was followed and if the resident had a medical condition/diagnosis which indicated the need for bed rails.
The assessment included the need for informed consent for rail usage, including the risk and benefits of use and a summary of rails, if any, to be used as a result of the assessment.

A. Resident #001 was observed in bed with two bed rails in the raised position in a specific location on the bed.
A review of the plan of care identified that the resident used, as a personal assistance service device (PASD) standard bed rails.
The resident had an order in place for standard bed rails engaged for bed mobility and resident request as a PASD.
A review of the most recent Bed Rail Risk Assessment completed April 2016, included a summary which identified that the resident was to use two bed rails for bed mobility and positioning; however, did not identify the location of the rails or the types of rails to be used.

B. Resident #004 was observed in bed with two bed rails in the raised position in a specific location on the bed.
A review of the plan of care identified that the resident used, as a PASD standard bed rails.
The resident had an order in place for standard bed rails engaged for bed mobility and hand controls.
A review of the most recent Bed Rail Risk Assessment completed May 2017, included a summary which identified that the resident was to use two bed rails for bed mobility and positioning; however, did not identify the location of the rails or the types of rails to be used.

C. Resident #003's bed system was observed to have tow bed rails in the raised position

of an unoccupied bed.
PSW #105 revealed that the resident used their bed rails to assist with bed mobility and transfers between bed and wheelchair, which was confirmed with the resident during an interview.
A review of the plan of care identified that the resident used, as a PASD, standard bilateral bed rails.
The resident had an order in place for the use of standard bed rails engaged to support bed mobility as a PASD.
A review of the most recent Bed Rail Risk Assessment, completed April 2016, included a summary which identified that the resident was to use two bed rails for bed mobility and positioning; however, did not identify the location of the rails or the types of rails to be used.

Interview with the acting Administrator and ADOC confirmed plans to review and revise their current Bed Rail Risk Assessment tool in accordance with prevailing practices. [s. 15. (1) (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 were bed rails are used, the resident is assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

According to RPN #101 resident #002 had a history of a condition.
A review of the clinical record identified that there was an increase in this symptom and an area of altered skin integrity was identified on a specified date in May 2017.
The resident continued to report the symptom and since this time had received orders for medication and treatment to promote comfort.
The resident was observed with an area of altered skin integrity.
Staff assessed the resident's skin in the progress notes, on a routine basis, in a Weekly Treatment Review note.
A review of the clinical record did not include an assessment of the new area of altered skin integrity when it was first identified by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment, which was confirmed with Nurse Manager #119, following a review of the record.
Interview with Nurse Manager #119 identified a clinically appropriate assessment tool in their electronic documentation system; however, due to an oversight the tool was not available or accessible for staff use prior to the concern being identified by the Inspector.
[s. 50. (2) (b) (i)]

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 resident with altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident which involved a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and was reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

On request the home provided a copy of all medication incidents and adverse drug reaction reports for 2017.
A review of the incident reports for March, April and May 2017, identified that that not all incidents were consistently documented, together with a record of the immediate actions taken to assess and maintain the resident's health, nor were they consistently reported to all required parties.
i. Resident #014 was involved in a medication incident in February 2017, which was identified the following month.

A review of the resident's record and medication incident report did not include a record of the immediate actions taken to assess and maintain the resident's health, nor that the incident was reported to the required persons as sets out in Ontario Regulation 79/10, which was confirmed by the ADOC following a review of the available documentation.
ii. Resident #015 was involved in a medication incident in March 2017, which was identified and reported the same day.
A review of the resident's record and medication incident report did not include a record of the immediate actions taken to assess and maintain the resident's health, nor that the incident was reported to all of the required persons as set out in Ontario Regulation 79/10, which was confirmed by the ADOC following a review of the available documentation.
iii. Resident #016 was involved in a medication incident in May 2017, which was identified and reported the same day.
A review of the resident's record and medication incident report did not include a record of the immediate actions taken to assess and maintain the resident's health, nor that the incident was reported to all of the required persons as set out in Ontario Regulation 79/10, which was confirmed by the ADOC following a review of the available documentation.

Interview with the acting Administrator and ADOC identified that the home had a process in place to fax all incident reports to the pharmacy; however, this action was not documented.
Plans were identified by the acting Administrator to revise the current Medication Incident Report document, to ensure that the form included all required documentation and parties for notification, for ease of documentation for staff. [s. 135. (1)]

2. The licensee failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed and corrective action was taken as necessary, and a written record was kept of everything required.

Medication incidents and adverse drug reactions reports for March, April and May, 2017, were provided on request and reviewed.
The records reviewed included sections to document investigation comments; follow up comments; comments by the physician and the nurse manager and recommendations of the committee (nursing management committee meeting). A number of the reports reviewed did not have all of these sections of the documents completed.
Interview with the acting Administrator and ADOC identified the current process to manage medication incidents and adverse drug reactions by the nursing management

included reviewing, analyzing and implementing corrective action; however, that this process was not consistently documented for all actions taken.

Not every medication incidents or adverse drug reactions had a written record of the review and analysis or corrective action taken. [s. 135. (2)]

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 every medication incident involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider and that all medication incidents and adverse drug reactions are documented, reviewed and analyzed and corrective action is taken as necessary, and a written record is kept of everything required, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were protected from abuse by anyone and free from neglect by the licensee or staff in the home.

Resident #012 was able to make decisions and had a diagnosis.
According to internal investigative notes and a Critical Incident System (CIS) report, the home received a complaint from PSW #103 that, on an identified date in April 2017, RPN #112 yelled at them regarding resident #012.
PSW #103 was not available for interview during the inspection.
When interviewed by the Inspector, the resident recalled the incident as it was reported and stated that the RPN "blasted" them and the PSW. They stated that this incident made them feel "not very good", that they felt put down and embarrassed.
During interview the Nurse Manager, who investigated the incident, reported that RPN #112 confirmed their actions toward PSW #103 and resident #012 and stated that they should not raise their voice and that the resident was able to make decisions.
The home's Nursing Manager and ADOC stated that the internal investigation determined that RPN #112 had verbally abused resident #012 and the outcome of the investigation.

PLEASE NOTE: This area of non compliance was identified during a Critical Incident System (CIS) inspection log #007921-17, conducted concurrently during this Resident Quality Inspection. [s. 19. (1)]

WN #7: 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. (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 failed to ensure that staff participated in the implementation of the infection prevention and control program.

A. The home's Infection Control policy "Routine Practices and Additional Precautions" number IC-02_06, last reviewed November 16, 2016, indicated "Keeping the

environment and resident care equipment clean is an important part of preventing the spread of infections within the healthcare setting. Reusable equipment that has been in direct contact with the resident must be cleaned and disinfected before use by another resident"; and "The user of shared resident equipment is responsible for the immediate cleaning after each use".

On three dates in 2017, an unlabelled urine collection receptacle, containing urine, was observed on the bathroom floor, of residents #018 and #019 room; signage on the bedroom door indicated "Contact Precautions" and personal protective equipment was available outside of the door.
When asked about the urine, PSW #104 stated that the urine must belong to resident #018; however, they could not be certain, nor did they know why the urine was in the bathroom; and confirmed the use of contact precautions, but did not know why, at the time of the interview.
Review of resident #018's health record indicated that urine had been collected by staff.
During interviews, PSW #104, RPN #116 and the Infection Control Practitioner indicated that any urine collected should have been disposed of immediately and not left in a urine collection container over a three day period.
The Infection Control Practitioner confirmed that staff had not followed the infection prevention and control program in relation to the handling of the urine.

B. The home's Infection Control policy "Prevention" number IC-02-06, last reviewed November 16, 2016, directed staff to "Clean and disinfect all shared equipment between each resident use routinely. Concentrate on the parts that have frequently touched surfaces (ie. Handle grips..)" and "Handle soiled equipment in a manner to prevent skin or mucous membrane exposures and to prevent contamination of clothing or the environment".

On July 17, 2017, Inspector #526 observed shower brushes hanging on grab bars in the shower stalls.
Shower brushes were noted to be hanging in shower stalls on July 19, 2017, by Inspector #168.
During interview, PSW #124 stated that the brushes were used to clean the commode chairs and tubs and that approximately 80 percent of residents on an identified home area used the shower and some resident used the grab bars during bathing.
During interviews on July 19 and 21, 2017, the home's ADOC and the acting Administrator confirmed that staff should hang the shower brushes on the hooks provided and not on the grab bars that may be use during bathing. [s. 229. (4)]

Issued on this 8th day of September, 2017

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

Original report signed by the inspector.