Ministry of Health and Long-Term Care

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch
Ottawa Service Area Office

347 Preston St., 4th Floor
Ottawa ON K1S 3J4
Telephone: 613-569-5602
Facsimile: 613-569-9670

Ministère de la Santé et des Soins de longue durée

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité
Bureau régional de services de Ottawa

347, rue Preston, 4iém étage
Ottawa ON K1S 3J4
Téléphone: 613-569-5602
Télécopieur: 613-569-9670

October 14, 2010

Ms. Deborah Skeaff
Administrator
Picton Manor Nursing Home
9 Hill Street
P.O. Box 920
Picton ON K0K 2T0

Dear Ms. Skeaff:

Please find enclosed the ***Inspection Report-Public Copy*** for inspections conducted on July 26 and 27, 2010 under the *Long-Term Care Homes Act, 2007* (LTCHA) for the purpose of ensuring compliance with requirements under the LTCHA.

These inspection reports must be posted in the home, in a conspicuous and easily accessible location in accordance with the LTCHA, 2007, S.O. 2007, c.8, s.79 (1) and (2).

A copy of the ***Inspection Report-Public Copy*** must be made available without charge upon request. These reports will also be on file with the Ottawa Service Area Office, Performance Improvement and Compliance Branch.

Sincerely,

Jessica Lapensée

For: Amanda Williams
LTC Home Inspector - Environmental

C President, Resident's Council
President, Family Council

Ontario

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

Rapport d'inspection prevue le *Loi de 2007 les foyers de soins de longue durée*

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Toronto Service Area Office
55 St. Clair Avenue West, 8th Floor

Telephone: 416-325-9297
1-866-311-8002
Facsimilie: 416-327-4486

Bureau régional de services de Toronto
55, avenue St. Clair ouest, 8iém étage
Ottawa ON K1S 3J4

Téléphone: 416-325-9297
1-866-311-8002
Télécopieur: 416-327-4486

☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**

Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'insptection**
July 26 & 27, 2010	2010_101_935_23Jul1 33626	Complaint (#O-000490)

Licensee/Titulaire

Seniorscare Operations (HCL) LP, 113 Yorkville Avenue, Suite 300, Toronto, ON M5R 1C1

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

Picton Manor, 9 Hill Street, P.O. Box 920, Picton, ON K0K 2T0

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

Amanda Williams (101)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection related to infection control practices and lack of communication and control measures to present the spread of a scabies outbreak declared by Public Health.

During the course of the inspection, the inspector spoke with: The Administrator, Director of Nursing, Environmental Services Manager, Registered Nursing staff, housekeepers, residents and front line nursing staff.
During the course of the inspection, the inspector conducted a walk-through of the home and observed staff practices and interactions with residents.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Accommodation-Housekeeping

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN
2 VPC
1 CO: CO # 001

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoye
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activitiés

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. Non-compliance with requirements under the *Long-Term Care Homes Act, 2007* (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)	Le suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with LTCHA 2007 S.O. 2007 c. 8 s. 15 (2)(a). **Every licensee of a long-term care home shall ensure that,**
(a) the home, furnishings and equipment are kept clean and sanitary;

Findings:

1. Five resident lounge chairs were soiled in the 1st floor lounge located beside room 130.

Inspector ID #:	101

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 all resident furniture is kept clean and sanitary including those identified above. This plan is to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA 2007 S.O. 2007 c. 8 s. 86(2)(b). **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).

Findings:

1. Inappropriate glove and use by staff as follows:
   a. On July 27, 2010- two Personal Support Workers (PSW) completed care in a resident room requiring isolation precaution techniques (wearing gloves and gowns) then exited the room and continued with routine work routines, including transporting of wheelchair dependent residents while wearing the same Personal Protective Equipment (PPE) .
   b. On July 26, 2010- four PSWs throughout the home donned PPEs inappropriately (i.e. gowns pulled on only to the forearms and/or gowns open at the front).
   c. On July 26 & 27, 2010- The potential transmission of infection by staff was noted. Four PSWs wore the same disposable gown and gloves while conducting care and transporting several

different residents throughout the home.

2. On July 26 & 27, 2010- clean re-useable gowns were stored in an unsanitary manner allowing easy access to potential contamination and spread of infection. Clean re-useable gowns were stored in laundry baskets on top of the 1st floor nursing station and on clean carts in hallways throughout the home.

Inspector ID #:	101

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order of the Inspector" form.

WN #3: The Licensee has failed to comply with O. Reg. 79/10 s. 229(4). **The licensee shall ensure that all staff participate in the implementation of the program.**

Findings:

1. Inappropriate glove and use by staff as follows:
   a. On July 27, 2010 two Personal Support Workers (PSW) completed care in a resident room requiring isolation precaution techniques (wearing gloves and gowns) then exited the room and continued with routine work routines, including transporting of wheelchair dependent residents with the same Personal Protective Equipment (PPE) on.
   b. On July 26, 2010- Four PSWs throughout the home donned PPEs inappropriately (i.e. gowns pulled on only to the forearms and/or gowns open at the front).
   c. On July 26 & 27, 2010- The potential transmission of infection by staff was noted. Four PSWs wore the same disposable gown and gloves while conducting care and transporting several different residents throughout the home.

Inspector ID #:	101

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 all staff participate in the implementation of the infection control program. This includes knowledge and implementation of appropriate use and application of personal protective equipment. This plan is to be implemented voluntarily.

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	**Date of Report (if different from date(s) of inspection).** September 23, 2010

Ontario

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

Rapport d'inspection prevue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
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Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'insptection**
July 26 & 27, 2010	2010_101_935_25Aug 114055	Other

Licensee/Titulaire

Seniorscare Operations (HCL) LP, 113 Yorkville Avenue, Suite 300, Toronto, ON M5R 1C1

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

Picton Manor, 9 Hill Street, P.O. Box 920, Picton, ON K0K 2T0

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

Amanda Williams (101)

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a special visit inspection following issues identified during a complaint inspection.

During the course of the inspection, the inspector spoke with: the Administrator, Director of Care (DOC), Registered Nursing (RN) staff, front-line nursing staff, and housekeeping staff.

During the course of the inspection, the inspector: conducted a walk-through of resident home areas

The following Inspection Protocols were used during this inspection:
Safe and Secure
Medication

☒ Findings of Non-Compliance were found during this inspection. The following action was taken:

6 WN
6 CO: CO # 001, #002, #003, #004, #005, and #006

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
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CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activitiés

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. Non-compliance with requirements under the *Long-Term Care Homes Act, 2007* (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.)	Le suivant constituer un avis d'ecrit de l'exigences prevue le paragraph 1 de section 152 de les foyers de soins de longue dureé. Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue dureé* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prevue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with the 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:

1. On July 26, 2010- Within the 1st floor hallway, outside of room 129, a lift chair was stored with the wheels not locked and the legs sticking out creating a potential trip and fall hazard.
2. On July 27, 2010 – The 1st floor tub room door was left open, with the tub filling up with water, and the room left unattended and accessible to residents creating a potential drown hazard.

Inspector ID #:	101

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #2: The Licensee has failed to comply with O. Reg. 79/10 s. 129 (1)(a)(i) and (ii). **Every licensee of a long-term care home shall ensure that,**
(a)drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies
(ii) that is secure and locked

Findings:

1. On July 26, 2010 at ~5:40pm- the Director of Care's (DOC) office was left open and unlocked, following the DOC leaving the building for the evening. Two registered staff stated the door is always kept open throughout the evening. One resident accessed the room to obtain and return her cigarettes and lighter. The following items were present within the DOC's office, accessible to staff, residents, visitors, etc.:
    a) Six containers of prescribed treatment lotion (Kwellada) present on top of the DOC's desk.
    b) Discarded/expired medications stored in two plastic containers located under the DOC's desk

c) Keys to the 1st floor narcotic and medication cart located on a hook behind the DOC office door along with other keys to unknown locations.

2. On July 26, 2010 on the 1st floor – several prescribed treatment creams (>10) were stored in a plastic basket on top of a treatment cart, unattended and accessible to residents. The cart was stored outside of room 110. Three residents were present in the area at the time of the observation. The Charge Nurse was inside the medication room located around the corner from the room.
3. On July 27, 2010- More than 6 containers of prescribed treatment lotions (Kwellada) were left accessible to residents on an overbed table located outside the nursing station and DOC office on the 1st floor resident home area.

Inspector ID #:	101

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg. 79/10 s. 130 (1). **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.

Findings:

1. On July 26, 2010 at ~5:40pm- the Director of Care's (DOC) office was left open and unlocked, following the DOC leaving the building for the evening. Two registered staff stated the door is always kept open throughout the evening. The following items were present within the DOC's office, accessible to staff, residents, visitors, etc.:
   a. Six containers of prescribed treatment lotion (Kwellada) present on top of the DOC's desk.
   b. Discarded/expired medications stored in two plastic containers located under the DOC's desk
   c. Keys to the 1st floor narcotic and medication cart located on a hook behind the DOC office door along with other keys to unknown locations.

Inspector ID #:	101

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #4: The Licensee has failed to comply with O. Reg. 79/10 s. 130 (2). **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:**
2. Access to these area shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator

Findings:
1. On July 26, 2010 at ~5:40pm- the Director of Care's (DOC) office was left open and unlocked, following the DOC leaving the building for the evening. Two registered staff stated the door is always kept open

throughout the evening. The following activity was noted while the writer was present in the room:
   a. One resident accessed the room to obtain and return her cigarettes and lighter twice while the writer was present in the room.
   b. Two Personal Support Workers (PSWs) entered and exited the room to leave written messages for the DOC on her desk.
2. The following items were present within the DOC's office, accessible to staff, residents, visitors, etc.:
   a. Six containers of prescribed treatment lotion (Kwellada) kept on top of the DOC's desk.
   b. Discarded/expired medications stored in two plastic containers located under the DOC's desk
   c. Keys to the 1st floor narcotic and medication cart located on a hook behind the DOC office door along with other keys to unknown locations.

Inspector ID #:	101

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #5: The Licensee has failed to comply with LTCHA 2007, S.O. 2007, c. 8 s.3(1)(11)(iv). **Every resident has the right to,**
iv) have his or her personal health information within the meaning of the *Personal Health Information Protection Act, 2004* kept confidential in accordance with the Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

Findings:
1. On July 26, 2010 at ~5:40pm - The Director of Care's (DOC) office was left open, unlocked and unattended following the DOC leaving the building fro the day. Present and accessible to staff, residents, visitors, etc. were resident files and personal health information on top of the DOC's desk and in an unlocked filing cabinet.
   a. Two registered staff stated the door is always kept open throughout the evening.
   b. The following activity was noted while the writer was present in the room:
      - One resident accessed the room to obtain and return her cigarettes and lighter twice while the writer was present in the room.
      - Two Personal Support Workers (PSWs) entered and exited the room to leave written messages for the DOC on her desk while the writer was present.

Inspector ID #:	101

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector" form.

WN #6: The Licensee has failed to comply with O. Reg. 79/10 s. 91. **Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times.**

Findings:
1. On July 26, 2010 at ~5:39 pm, a spray bottle of disinfectant (Quatro) was left on top of a residents' dresser with the resident lying on their bed. Housekeeping's shift ends daily at 3pm.
2. On July 27, 2010 at ~9:10am- a housekeeping cart was left in the 1st floor hallway unattended

outside resident rooms with two spray bottles of disinfectant (Quatro) present on top of the cart.

3. On July 27, 2010- the 1st floor tub room door was left open and a spray bottle of disinfectant (Quatro) was left on top of the closed toilet seat, accessible to residents.
4. On July 27, 2010- Two bottles of disinfectant (Quatro) was left on top of the 1st floor nursing station, accessible to residents.
5. On July 27, 2010- Three spray bottles of disinfectant (Quatro) were left on top of handrails throughout the 1st floor corridor, accessible to residents.

Inspector ID #:	101

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector" form.

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**	**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title: **Date:**	**Date of Report (if different from date(s) of inspection).** September 23, 2010