Ontario

Inspection Report Under the
**Fixing Long-Term Care Act, 2021**

**Ministry of Long-Term Care**
Long-Term Care Operations Division
Long-Term Care Inspections Branch

**Central East District**
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# Original Public Report

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| **Report Issue Date: October 1, 2024** | |
| **Inspection Number:** 2024-1196-0002 | |
| **Inspection Type:**<br>Critical Incident | |
| **Licensee:** The Royale Development GP Corporation as general partner of The Royale Development LP | |
| **Long Term Care Home and City:** Bloomington Cove Community, Stouffville | |
| **Lead Inspector**<br>The Inspector | **Inspector Digital Signature** |
| **Additional Inspector(s)** | |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 27 - 30, 2024 and September 4, 5, 2024

The following intake(s) were inspected:

- An intake related to falls prevention and management
- An intake related to prevention of abuse and neglect

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Housekeeping, Laundry and Maintenance Services

Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: RESIDENTS' BILL OF RIGHTS

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: FLTCA, 2021, s. 3 (1) 4.**

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

4. Every resident has the right to freedom from abuse.

The licensee has failed to ensure that a resident was free from abuse from staff.

**Rationale and Summary**

A critical incident report (CIR) submitted to the Director indicated that staff had overheard a PSW speak inappropriately to a resident in their room.

The staff member had confirmed that they had overheard the interaction between the PSW and a resident and had also observed only one PSW had exited the resident's room. The PSW confirmed they had spoken inappropriately to a resident during their verbal interaction while providing care to the resident.

Assistant Director of Care (ADOC) acknowledged that the interaction between the PSW and the resident constituted abuse.

Failure to protect the resident from verbal abuse could have negatively impacted the resident's quality of life.

**Sources:** CIR, home's investigation notes, resident's records, interviews with staff.

## WRITTEN NOTIFICATION: SAFE AND SECURE HOME

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 5**
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

1. The licensee has failed to ensure that a resident home area lounge is a safe environment for its residents.

**Rationale and Summary**
During a tour of the home, it was observed that the lighting appeared dim for the ten residents who were sitting in the resident's lounge. It was observed that six of the thirteen pot lights in the lounge were not functional. On three dates in August 2024, four pot lights were repaired. During the last date of inspection, two pot lights still remained not functional.

The Environmental Services Manager (ESM) confirmed they did complete an audit of the specified unit, but did not go into the lounge and were not aware that six pot lights were not functional. The ESM confirmed that the process is for staff to make the ESM aware of repairs in the home. A PSW confirmed they were aware of the dim

lighting but did not report the issue to the online Maintenance care portal, but instead reported it to a housekeeper. The Administrator confirmed during the exit interview, that the two remaining pot lights in the specified lounge remain not functional.

Failure to repair lighting placed the residents at risk of an unsafe environment.

**Sources:** Observations, interviews with staff.

2. The home has failed to ensure that an outdoor area is a safe and secure environment for its residents.

**Rationale and Summary**
During a tour of the home it was observed that a specified outdoor area was unusable by residents, it had two sections of the fence missing and a red plastic temporary fence in place with no outdoor furnishings available for use. A sign on the door indicated that the unit was temporarily closed and directed families and residents to a West Side patio on the opposite side of the home. It was observed that the outdoor furniture had been set up and yellow caution tape was around the missing fence area. The former sign had been replaced with new signage to indicate that only supervised visits with residents was allowed and directed families and residents to a West Side patio on the opposite side of the home. Further signage instruction included to keep away from any areas with yellow caution tape.

The ESM and Executive Director indicated that staff had knocked the fence down several months ago.

During an interview with the Executive Director a request was made to review the fence repair plan of action and was received three days later.

Interviews with the Executive Director and the ESM confirmed that they are aware that for several months the residents could not leave the unit, as a pass was needed to exit the unit. They confirmed that some residents had not been taken outside during the time the fence has been down, unless a family member took them to the West side patio, or if a resident was in a program to go outside.

A specified contracted service was awarded the contract to repair the roof but had not submitted a quote, or a plan for the scope of work. No repairs had been initiated during the time of the inspection.

Failure to provide the residents a safe and secure outdoor space to enjoy, placed the resident at risk of limited outdoor activity.

**Sources:** Observations, Interview with staff.

## WRITTEN NOTIFICATION: DUTY OF LICENSEE TO COMPLY WITH PLAN

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 6 (7)**
Plan of care
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.

The licensee failed to ensure that a resident's plan of care was provided to the resident as specified in the plan.

**Rationale and Summary**

A CIR was submitted to the Director related to an alleged abuse of a resident during care. A staff member confirmed they had overheard the interaction between a PSW and a resident and had also observed only one PSW had exited the resident's room after the interaction.

Review of the resident's plan of care indicated all personal care provided to the resident required two staff at all times for safety. Interviews with the resident and the PSW confirmed the PSW had provided personal care to the resident on their own. The PSW had stated they were aware that the resident required two staff.

Assistant Director of Care (ADOC) acknowledged it is the staff responsibility to ensure care is provided to the resident as specified in the plan of care.

Failing to ensure that two staff were present while providing personal care to the resident as directed in the plan of care, put the resident at risk for safety.

**Sources:** CIR, resident's records, home's investigation notes, interviews with staff.

## WRITTEN NOTIFICATION: ACCOMMODATION SERVICES

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: FLTCA, 2021, s. 19 (2) (c)**
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

1. The licensee has failed to ensure that the roof was maintained in a good state of repair.

**Rationale and Summary**

During a tour of the home, a PSW spoke to the inspector regarding the ceiling in a resident's dining room. They explained that when it rains, the water comes through an overhead bulk head, and the staff use white buckets to collect the water and have to move six tables of residents to another location in the dining room for the residents to be safe from potential falls.

Observations included:
- third floor identified unit main corridor had an overhead bulkhead with brown stains, chipped and peeling concrete, and in a state of disrepair
- second floor identified unit dining room had an overhead bulkhead with brown stains, chipped and peeling concrete, and in a state of disrepair

During an interview with the Executive Director (ED) a request was made to review the roof repair plan of action and was received three days later.

Interviews with the ED and the ESM confirmed that they are aware that the roof leak occurs when it rains in two areas of the home where residents walk in the identified unit main corridor, and the identified unit dining room. They confirmed the leaks have been occurring over several months. The ED confirmed that the specified contracted service was awarded the contract to repair the roof but had not submitted a quote, or a plan for the scope of work. No repairs had been initiated during the time of the inspection

The residents were at risk of falling when the roof leaked during times of rainfall when the home was not maintained in a good state of repair.

**Sources:** Observations, interviews with staff.

2. The home has failed to ensure that the walls, blinds and windows are in a good state of repair.

**Rationale and Summary**

During a tour of the home, the following was observed:

-A lounge ceiling and wall had broken concrete, open wall area and open ceiling tiles.

-Identified unit had four open areas in the in hallway where ceiling tiles were missing.

-Identified unit spa room had discoloured walls in the shower area.

-Identified unit - blinds broken and inoperable in a closed position in the resident lounge area

-Identified unit - blinds broken and inoperable in the dining room.

The ED and the ESM confirmed that they were unaware of the disrepair on the areas of the specified unit, but were aware of the lounge disrepair. They both also confirmed there was no plan of action in place to correct the areas of concern at the time of the inspection, but would address the areas of concern. The IPAC Lead confirmed they were unaware of the disrepair.

Failure to keep the blinds in a good state of repair placed the residents at risk of not enjoying the outside view. Failure to keep the walls and ceiling in a good state of repair was a risk to the residents of having their home in a state of disrepair and potential for infection.

**Sources:** Observations, interviews with staff.

## WRITTEN NOTIFICATION: AIR TEMPERATURE

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 24 (1)**
Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

The licensee has failed to ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

**Rationale and Summary**
During a tour of the home, a resident brought forward a concern and was interviewed regarding their air conditioning in their room.

A list of air temperature logs was requested from the home for a specified month in 2024, to the time of inspection. The Air Temperature Form identifies temperatures to be taken every morning, 1200-1700 hours (hrs), and in the evenings/night, from May 15 to September 15. The form indicated that the staff are to report and take action when the air temperatures fall below 22 degrees Celsius. An audit of the Air Temperature Form from a three month period in 2024, indicated eleven occasions the air temperature was less than 22 degrees Celsius in the home and no report or corrective actions taken.

The ESM confirmed that they do review the temperature logs, but was unaware of the eleven occasions where the temperature was less than 22 degrees Celsius in the home. The ESM confirmed that they have an expectation of the temperatures to be done as indicated on the Air Temperature Form and make a report to management and corrective action taken for the residents room. The Director of Care (DOC) was not aware that temperatures were to be taken in the home.

Failure to ensure that the temperature in the home did not fall below 22 degrees Celsius, placed the residents at risk of discomfort.

**Sources:** Resident concern, an audit of the homes' Air Temperature Form, interviews with a resident and staff.

## WRITTEN NOTIFICATION: AIR TEMPERATURE

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 24 (4) (a)**
Air temperature
s. 24 (4) In addition to the requirements in subsection (2), the licensee shall ensure that, for every resident bedroom in which air conditioning is not installed, operational and in good working order, the temperature is measured and documented in writing once a day in the afternoon between 12 p.m. and 5 p.m. on,
(a) every day during the period of May 15 to September 15.

The Licensee has failed to ensure that, for every resident bedroom in which air conditioning is not operational, the temperature is measured and documented in writing once a day in the afternoon between 12 p.m. and 5 p.m. every day during the period of May 15 to September 15.

**Rationale and Summary**
During a tour of the home, a resident was interviewed and they identified that their air conditioner was installed but sounded like loud popcorn noise during the evening and night time, when it is their preference to have the air conditioning operational. The resident had mention this to staff, five days prior to the inspection.

A record review of the Air Temperature Logs indicated that temperatures were not

taken in the resident's room for a specified nine days.

The ESM acknowledged that the temperatures of the resident's room was not taken and they would expect staff to complete and document once a day in the afternoon between 12 p.m. and 5 p.m. every day during the period of May 15 to September 15, if any residents' air conditioner was not operational.

There was an increase in risk to residents related to heat related illnesses when room temperatures were not monitored.

**Sources:** Interviews with staff and resident, Air temperature logs.

## WRITTEN NOTIFICATION: HOUSEKEEPING

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (ii)**
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (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:
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and

As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee has failed to ensure that procedures are developed and implemented for, 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:(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids.

**Rationale and Summary**
During the tour of the home, two pieces of resident care equipment were observed. Two specific lifts were in separate spa rooms, with slings labelled with the specified home area names were laid across the lifts.

As per the Provincial Infectious Diseases Advisory Committee (PIDAC) Best Practices for Environmental Cleaning for Prevention and Control of Infections, hydraulic lift slings are to be laundered in between patients and when soiled, and dedicated to a resident if possible.

The IPAC Lead confirmed that they were not aware that slings cannot be used on several residents and that every resident should have a dedicated sling for their personal use. A PSW confirmed that slings are not to be shared amongst residents and that everyone has their own sling.

By not ensuring procedures were implemented regarding cleaning and disinfection practices for hydraulic lift slings, there was a potential risk for the spread of infectious agents amongst residents.

**Sources:** Observations, Ontario Agency for Health Protection and Promotion (Public Health Ontario), Provincial Infectious Diseases Advisory Committee. Best practices for environmental cleaning for prevention and control of infections in all health care settings. 3rd ed., interviews with staff.

## WRITTEN NOTIFICATION: MAINTENANCE SERVICES

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 96 (2) (d)**

Maintenance services

s. 96 (2) The licensee shall ensure that procedures are developed and implemented to ensure that,

(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;

The licensee has failed to ensure that procedures are developed and implemented to ensure that,(d) all plumbing fixtures, sinks, washroom fixtures and accessories are maintained and kept free of corrosion and cracks.

**Rationale and Summary**

During a tour of the home, a PSW identified that in a specified spa room, the resident sink and counter is not secured to the wall, and the under sink plumbing leaks when the water is turned on and the water drained into a bowl under the sink. The PSW confirmed this had been ongoing for several months.

The ESM confirmed they do audits of resident spa rooms, but was not aware of the sink and counter which was not secured to the wall, and under sink plumbing was leaking and drained into a bowl. The ED confirmed that they were not aware of the situation, and that the home had not made arrangements for any repairs to be completed.

Failure to ensure that the resident sink and counter was secured to the wall, and the under sink plumbing was free from leaks placed the resident at risk of harm and a fall.

**Sources:** Observations of spa room, interviews with staff.

## WRITTEN NOTIFICATION: HAZARDOUS SUBSTANCES

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 97**
Hazardous substances
s. 97. 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.

The licensee has failed to ensure that all hazardous substances are kept inaccessible to residents at all times.

**Rationale and Summary**
During a tour of the home, it was observed that a housekeeping cart was left in the hallway unsupervised and unlocked with hazardous chemicals, while the housekeeper was in a meeting.

The Housekeeper confirmed that the housekeeping cart was left unsupervised and unlocked with hazardous chemicals and should not have done so.

The ESM confirmed that all housekeeping carts in the home that contain hazardous chemicals are to be locked while unsupervised as per the home's policy.

Failure to keep a housekeeping cart locked that contains hazardous chemicals placed the residents at risk of injury.

**Sources:** Observations, interviews with staff.

## WRITTEN NOTIFICATION: LICENSEES WHO REPORT INVESTIGATIONS UNDER s. 27 (2) OF ACT

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 112 (1) 2. ii.**

Licensees who report investigations under s. 27 (2) of Act

s. 112 (1) In making a report to the Director under subsection 27 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:

2. A description of the individuals involved in the incident, including,

ii. names of any staff members or other persons who were present at or discovered the incident, and

The licensee failed to ensure that reports made to the Director included the names of any staff members who were present at the incident.

**Rationale and Summary**

A review of CIR submitted to the Director, did not include the name of the CSA staff who was present at the incident.

An ADOC confirmed in this report to the Director did not include the above-mentioned information.

There was low risk to resident when the licensee did not include the staff member's name who were present at the incident.

**Sources:** CIR, interview with staff.

## WRITTEN NOTIFICATION: LICENSEES WHO REPORT INVESTIGATIONS UNDER s. 27 (2) OF ACT

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 112 (1) 2. iii.**

Licensees who report investigations under s. 27 (2) of Act

s. 112 (1) In making a report to the Director under subsection 27 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:

2. A description of the individuals involved in the incident, including,

iii. names of staff members who responded or are responding to the incident.

The licensee failed to ensure that reports made to the Director included the full names of any staff members who responded to the incident.

**Rationale and Summary**

A review of CIR submitted to the Director did not include the names of staff members who responded to the incident.

An ADOC confirmed in this report did not include the above-mentioned information.

There was low risk to resident when the licensee did not include the staff member's names who responded to the incident.

**Sources:** CIR, interview with staff.

## WRITTEN NOTIFICATION: REPORTS RE CRITICAL INCIDENTS

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 115 (5) 2. ii.**
Reports re critical incidents
s. 115 (5) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (4) 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,
ii. names of any staff members or other persons who were present at or discovered the incident, and

The licensee failed to ensure that reports made to the Director included the names of any staff members who were present at or discovered the incident.

**Rationale and Summary**
A review of a critical incident report (CIR) submitted to the Director did not include the full names of staff members who were present and who discovered the fall incident.

An ADOC confirmed in this report did not include the above-mentioned information.

There was low risk to resident when the licensee did not include the full staff member's names were present and who discovered the incident.

**Sources**: CIR, interview with staff.

## WRITTEN NOTIFICATION: CMOHH and MOH

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 272**
CMOH and MOH

s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

The licensee has failed to ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home. Specifically, s. 3.12, which states that a minimum twice daily for high touch surfaces (door handles/knobs, light switches, handrails, phones, elevator buttons, etc.), treatment areas, dining areas and lounge areas are to be cleaned during an outbreak.

**Rationale and Summary**
On a specified date and resident home area an outbreak began. The housekeeping schedule confirmed that they worked 0800-1300 hours (hrs).

The Environmental Services Supervisor (ESM) confirmed that the housekeeper was to work from 0800-1600 hrs, instead of the usual schedule of 0800-1300 hrs during an outbreak. When the Public Health Inspector came on site, they were also told by the ESM, that the housekeeper was to work 0800-1600 hrs during an outbreak, but the housekeeper had left at 1300 hrs. The ESM also confirmed that after the housekeeper had left for the day, then the PSW staff were to do necessary cleaning during an outbreak, however the PSW job description did not include cleaning of high touch surfaces, or any education on cleaning to the PSW of high touch surfaces.

In an email received by the inspector, the IPAC Lead had indicated that the home had planned to have 7.5 hours scheduled for housekeeping daily until the outbreak

is over, however due to non-availability of staff this did not happen. A plan was made on the following day to have a Care Support Assistant (CSA) who was a new employee to look for garbage and report to the nurse if there were any concerns. The IPAC Lead did not address high touch surface disinfection in the plan, and confirmed the CSA had a regular onboarding orientation completed, not specific to housekeeping. The IPAC Lead confirmed the job role of the CSA was to work on the floor assisting PSW team members and sometimes do one to one for some residents. The IPAC lead and ESM confirmed that no one completed the high touch cleaning on the outbreak resident home area.

Failure to do high touch cleaning during a respiratory outbreak may have contributed to the spread of infection.

**Sources:** Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings Ministry of Health Effective: April 2024, interviews with staff, email correspondence.

## COMPLIANCE ORDER CO #001 Windows

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: O. Reg. 246/22, s. 19**
Windows
s. 19. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**

1. The Executive Director and ESM will conduct a comprehensive audit of the home to ensure that every window that opens to the outdoors and is

accessible to residents has a fitted screen and operational cranks handles.

2. The Executive Director and ESM will contract a Window Repair and Replacement Company to carry out any identified repairs.
3. The home will keep documentation of all audits including dates and names of staff completing the audits, plans of action, and evidence of the completion of work from a Window Repair and Replacement Company. Make available to the inspector immediately upon request.

**Grounds**

The licensee has failed to ensure every window in the home that opens to the outdoors and is accessible to residents has a screen.

**Rationale and Summary**

An initial tour of the home identified several resident room windows throughout the home had signs on them to indicate the window was broken. Several resident room windows did not have a screen, or ill-fitting screen and there was no crank to open or close the window.

The ESM and the Executive Director confirmed the screens should be fitted to the windows, and those screens that were not fitting the windows should have been replaced. The ESM acknowledged that windows without cranks, windows that did not have fitted screens and windows without screens put the resident's safety at risk. The ESM confirmed that in some resident rooms, they removed the cranks as another resident was known to exit seek.

Failing to ensure the windows accessible to residents had screens, the cranks, and fitted the window, may put the residents' safety and choice at risk.

**Sources:** Observations, and interview with the staff.

**This order must be complied with by** December 13, 2024

## COMPLIANCE ORDER CO #002 AIR TEMPERATURE

NC #015 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

**Non-compliance with: O. Reg. 246/22, s. 24 (2) 2.**

Air temperature

s. 24 (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:

2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor.

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**

1. The Management Team, Environmental Service Manager (ESM), Maintenance Staff, including all Registered staff and Agency Registered staff, will be trained by a representative of the Blue Rover company on the functions and maintenance on the Blue Rover Air Monitoring System.
2. The home will develop and implement a process for the staff to report any concerns regarding the Blue Rover Air Monitoring System.
3. The ESM will audit the system once a week electronically to ensure the Blue Rover Air Monitoring System is functioning properly and review any concerns and corrective action taken with the Executive Director. This will be done daily for one month.
4. All audits and training will be documented, including dates and employee names and provide a record to the inspector immediately upon request.

**Grounds**

The licensee has failed to ensure that the temperature is measured and documented in writing, specifically 2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor.

**Rationale and Summary**

During a tour of the home, observations included specified Air Monitoring System in common areas and dining rooms.

A request was made to the ESM for the specified Air Monitoring System records from dates in May until August 2024, for resident common areas, on every unit which may include a lounge, dining area or corridor. The Executive Director (ED) emailed the specified Company as the home had no available online records for several months. The Air Monitoring Company explained that their devices throughout the home were thought to have low battery and not reporting any temperatures.

The Environmental Services Manager (ESM) confirmed that they reviewed the electronic the specified Air Monitoring System records two weeks prior to the inspection, however the company had indicated that there were no air temperature readings since a specified date in May 2024. The ED confirmed that the expectation of the ESM, was to ensure that the specified Air Monitoring System is functioning to measure air temperatures of resident common areas, on every unit which may include a lounge, dining area or corridor. Both the ESM and the ED confirmed they did not know how the specified Air Monitoring System worked and were not aware that they were battery operated.

Failure to measure air temperatures in resident common areas, on every unit which may include a lounge, dining area or corridor throughout the home placed all residents at risk of a heat related illness.

**Sources:** Observations of the home, emails from the home to the monitoring company, interviews with staff.

**This order must be complied with by** November 27, 2024

## COMPLIANCE ORDER CO #003 COMPLIANCE WITH MANUFACTURERS' INSTRUCTIONS

NC #016 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: O. Reg. 246/22, s. 26**
Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**

1. A supply of specified Testing Containers and Strips are to be made available in every housekeeping closet throughout the home and on every housekeeping cart.
2. The specified sales representative will educate the IPAC Lead, ESM, DOC, and all Housekeeping Staff on the proper procedures for testing of the specified Disinfectant Cleaner, interpretation, and completing the Disinfectant Titration

Tracking Form.

3. The ESM will audit, the use of the specified Testing Strips and the Disinfectant Titration Tracking Form on each resident home area, every Monday for four weeks and educate every incident of noncompliance of this process.
4. Keep a documented record of the audits completed, along with the name of the person who completed the audit, the name of the staff who was audited, the date the audit was performed, include any corrective action taken and make available for Inspectors immediately upon request.

**Grounds**

The licensee has failed to ensure that housekeeping staff use all equipment, supplies, in the home in accordance with manufacturers' instructions.

**Rationale and Summary**

During a tour of the home, an identified disinfectant wall unit was observed in several housekeeping closets which were being used by the home to dilute and dispense a specific disinfectant and cleaner used for cleaning and disinfection of contact surfaces in resident areas.

A housekeeper confirmed that the housekeeping staff were expected to test the concentration of the disinfectant and cleaner dispensed from the wall unit every Monday and record the readings on the Disinfectant Titration Tracking Form. Housekeeping staff did not have any of the specified testing strip container with testing strips in the housekeeping closet. The Disinfectant Titration Tracking Form identified the last recorded reading of the home's disinfectant concentration levels was one day in July 2024, for one unit, and one day in August 2024, for another unit. One unit had a missing entry for one day in August 2024.

The ESM was not aware of the incomplete Disinfectant Titration Tracking Form in two areas of the home and confirmed that they should be completed. The ESM confirmed that a housekeeper did not have a chemical testing container with chemical testing strips available.

By failing to ensure that staff used all equipment, supplies, and devices in the home, in accordance with manufacturers' instructions, the licensee increased the risk for health care associated infections.

**Sources:** Disinfectant dispenser equipment observation, Disinfectant Titration Tracking Form, Chemical Disinfectant -Housekeeping Policy XII-G-10.10, interviews with staff.

**This order must be complied with by** November 27, 2024

## COMPLIANCE ORDER CO #004 HOUSEKEEPING

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: O. Reg. 246/22, s. 93 (2) (a) (i)**
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (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

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**
1. The Environmental Service Manager (ESM) will audit three different random rooms

on each resident home area, three times weekly, to ensure the housekeeping staff are completing the daily cleaning of resident rooms as scheduled. Audits will be completed for a period of 4 weeks.
2. The ESM will review the audits with the Executive Director, when completed after 4 weeks, and they will develop a corrective plan of action for any identified areas of non-compliance with daily cleaning of residents' rooms. The corrective plan of action, if any, will be implemented with one week of the completion of the audits.
3. Keep a documented log of all audits including dates, and plans of action, and make available to the inspector upon request.

**Grounds**
The licensee has failed to ensure the procedures were implemented for cleaning of the home, including, resident bedrooms, as part of the organized program of housekeeping.

**Rationale and Summary**
During the inspection, an interview with a housekeeper was conducted regarding the cleaning schedule on a resident home area unit. They indicated they only work 0800-1300 hours (hrs) and do not complete all of the cleaning of the residents' rooms for the unit on their shift. The housekeeper indicated they do as much cleaning as time allows and then ensure that all the garbage on the unit is disposed of before leaving their shift.

A record review was conducted of the homes' Resident Room Housekeeping Audits completed by the ESM and various team members for a specified two month period in 2024, and the audit indicated the following rooms are marked a "no" with no follow up flagged or any comments:

-High Dusting not done in 17 rooms

-Bedside table dusting in two rooms
-Call bell Cords and Cord Lights dusting in four rooms
-Chairs and other furniture in room not cleaned in two rooms
-Windows and windowsills not cleaned in two rooms
-Incomplete documented audit for three rooms

The Housekeeping Schedule was as follows for the day shift: Three units each has a housekeeper staffed 0800-1300 hours (hrs). One unit has a housekeeper staffed 0700-1500 hrs. Common Areas throughout the home has a housekeeper staffed for 0800-1430 hrs. There was no housekeeping scheduled throughout the home for the evening shift.

Interviews with three housekeepers indicated that they cannot complete all the necessary work in the allotted time, and they restart their work from where they left off from the day prior. The housekeepers also confirmed that the ESM is aware that there are areas of the home where cleaning is incomplete. The ESM confirmed that the housekeepers do not finish their daily cleaning of resident rooms and the ED was aware as the ESM had submitted several written Housekeeping Program reviews. The DOC was not aware of the cleaning schedules of the home. The ED was aware of the Housekeeping Program reviews and that the cleaning of resident rooms were not completed.

There was risk for infection control identified when the licensee failed to ensure the procedures were implemented for cleaning of resident bedrooms, as part of the organized program of housekeeping.

**Sources:** Housekeeping Staff Schedule, Observations, Resident Room Housekeeping Audits, Housekeeping Program reviews Interviews with staff.

**This order must be complied with by** November 27, 2024

## REVIEW/APPEAL INFORMATION

**TAKE NOTICE**

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

**Director**
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care

438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice

must be given to both HSARB and the Director:

**Health Services Appeal and Review Board**
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

**Director**
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.