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 West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: November 21, 2024
Inspection Number: 2024-1272-0006
Inspection Type: Follow up
Licensee: Collingwood Nursing Home Limited
Long Term Care Home and City: Collingwood Nursing Home, Collingwood

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 4, 5, 6, 2024

The following was inspected:

- Follow-up #: 1 - FLTCA, 2021 - s. 19 (2) (c)
- Follow-up #: 1 - O. Reg. 246/22 - s. 96 (1) (b)
- Follow-up #: 1 - O. Reg. 246/22 - s. 102 (2) (b)

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1272-0004 related to FLTCA, 2021, s. 19 (2) (c)
Order #002 from Inspection #2024-1272-0004 related to O. Reg. 246/22, s. 96 (1) (b)
Order #003 from Inspection #2024-1272-0004 related to O. Reg. 246/22, s. 102 (2) (b)

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

Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Food production

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 78 (7) (c)
Food production
s. 78 (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(c) a cleaning schedule for the food production, servery and dishwashing areas. O. Reg. 246/22, s. 78 (7).

The licensee has failed to ensure that the staff of the home complied with cleaning schedules for the food production, servery and dishwashing areas.

Summary and Rationale

A tour of the kitchen, servery and dishwash areas was conducted with the Food Services Manager on November 4, 2024, and revealed the following;

- Accumulated unknown liquid substance pooled on the floor at the back of the walk-in cooler which remained throughout duration of inspection.
- Accumulated food matter stuck to wall tiles behind the dishwasher and on the exterior surfaces of the dishwasher which remained throughout duration of inspection.
- Visible matter noted on the exterior surfaces of the stove and steam table

(cleaned by end of day November 4, 2024),

- Visible stains noted on the lower cabinetry in the servery which remained throughout duration of the inspection.
- Three separate food storage carts in the kitchen visibly soiled (one cleaned by end of day November 4, 2024).
- Heavy scale and copper precipitate noted around the faucet on the three-compartment sink.

A cleaning schedule was developed for staff to follow, which included what surfaces and equipment required daily and weekly cleaning. According to several dietary aides, the dietary department was often short staffed, and cleaning could not be completed as often as required or as necessary.

Cleaning schedules for the month of October 2024 were reviewed for three separate staff positions and revealed the following:

- Cook (10 a.m. to 6 p.m. shift) did not attest that certain equipment and surfaces were cleaned daily except for seven days out of the month.
- Receiving aide (9 a.m. to 1 p.m.), who was required to clean surfaces and equipment in the walk-in cooler and various other areas once per week, attested to completing the tasks for two weeks in October only.
- Afternoon aide (11 a.m. to 7 p.m.) did not attest that certain equipment and surfaces were cleaned daily for eleven days out of the month.

Failure to ensure that adequate staffing is allocated to complete the necessary cleaning according to cleaning schedules increases the likelihood of cross-contamination between dirty surfaces and food items.

Sources: Observations, interview with the Food Services Manager, review of cleaning schedules, cleaning audits and procedures.

WRITTEN NOTIFICATION: Infection prevention and control

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The licensee has failed to ensure that all staff, specifically personal support workers (PSWs) participated in the implementation of the infection prevention and control (IPAC) program.

Summary and Rationale

The licensee's IPAC program included a procedure for the handling of reusable non-critical devices such as bedpans, urinals, and washbasins. The procedure included how to wash, disinfect, and properly store the devices after use. PSWs were provided with training by the IPAC lead regarding the procedure in September 2024. Based on the following observations, some PSWs have not implemented the practices they were taught:

- Washbasins were observed stored upside down in resident ensuite washroom hand sinks in rooms #1, #2, #8, #18, #24. #25, and #31. Some were observed in the sink for several days. The procedure required staff to store the device in the resident's room (bedside table as per IPAC lead) after cleaning and disinfecting.
- A visibly soiled urinal was observed on the washroom vanity in washroom #31 for three days.

- A visibly soiled bedpan was observed on top of the toilet tank in washroom #8 for three days.
- A visibly soiled bed pan was observed inside of a white paper bag tucked behind a towel bar in washroom #17 for three days.
- An unlabeled bedpan was tucked behind the grab bar in washroom #15 (a shared washroom).
- The south wing soiled utility room did not have any liquid disinfectant or disinfectant wipes readily available for staff use on November 4, 2024. On November 5, 2024, a container of disinfectant wipes was noted on the counter, but it had not been opened and remained sealed when checked on November 6, 2024. The room and counter space were also overly cluttered for three days, thereby making any cleaning and disinfection processes difficult.
- Both soiled utility rooms had a large container of green soap on the counter for PSWs to use for device cleaning but was difficult to use and required a pump dispenser.

Failure to follow the cleaning, disinfecting and storage procedures for re-useable non-critical devices, which are part of the IPAC program may lead to the transmission of communicable diseases.

Sources: Interview with the IPAC lead, PSWs, observations and review of Cleaning and Disinfecting of Reusable Medical Equipment procedure and Best Practices for Cleaning, Disinfection and Sterilization in All Health Care Settings | May 2013.

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