Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l’inspection	Log # / No de registre	Type of Inspection / Genre d’inspection
Dec 9, 2021	2021_869120_0002	019009-21	Other

Licensee/Titulaire de permis

Holland Christian Homes Inc.
7900 McLaughlin Road South Brampton ON L6Y 5A7

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

Faith Manor Nursing Home
7934 Mclaughlin Road South Brampton ON L6Y 5A7

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

BERNADETTE SUSNIK (120), JANET GROUX (606)

Inspection Summary/Résumé de l’inspection

The purpose of this inspection was to conduct an Other inspection.

This inspection was conducted on the following date(s): November 29 & 30, 2021

A post occupancy inspection was conducted following the transfer of residents from their former long term care home to a newly built long term care home on the same property and the admission of additional residents beginning in July 2021.

During the course of the inspection, the inspectors toured the home, took water and air temperatures, observed meal service, staff to resident interactions, reviewed relevant policies and procedures, infection prevention and control practices, the posting of Ministry information, general sanitation, general maintenance and availability of equipment, linens and supplies.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Environmental Services, Director of Resident Care, Housekeeping/Laundry Manager, Dietary Manager, Infection Prevention and Control Program Co-ordinator, Director of Programs and Services, Emergency Management Co-ordinator, registered staff, personal support workers (PSWs), dietary aides, maintenance staff and residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Dining Observation
Infection Prevention and Control
Medication
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
6 WN(s)
0 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	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors to non-residential areas are locked when not supervised by staff.

Non-residential areas include spaces that are not designed for resident use such as housekeeping closets, utility rooms and any other spaces where supervision is required for safety or security purposes.

A door to an interior space currently undergoing major renovations was not secured or locked in the main foyer area of the home. Although nursing staff were present in the area from 5 a.m. to 11:30 p.m., to screen visitors upon entry, they were not specifically directed to supervise the door to the construction site, and the area is left unattended after 11:30 p.m.

Although all utility rooms were equipped with a lock, three were found unlocked on different floors during the inspection. A door on a linen chute room could be pushed open as the door could not latch. The striker plate for the latch was stuffed with paper towel. The combination push button lock on a linen chute room on a different floor was not functioning properly to allow the door to latch and lock. The clean utility room on the same floor, which is required to self-close and latch, would not latch when it closed unless the door was pulled closed. A therapy room that was converted into a temporary locker room for staff and which also included a very hot hydrocollator was left unlocked on two separate occasions. It was locked by the inspector at the time of observation. Upon return the following day, the room was unlocked. With the exception of the door to the construction area, none of the non-residential rooms were occupied by staff or had staff supervising the rooms at the time of observation.

Source: Observations, staff interviews [s. 9. (1) 2.]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home was kept clean and sanitary.

The main kitchen flooring material was observed to be black in the room just before entrance to the kitchen, at the entrance area to the kitchen, along the coved baseboards and in front of and under all fixed equipment. The supply air grille and ceiling tile next to it located near the steamer was covered in black dust. A drain under the dessert table was clogged with debris. An area under the dessert table had a heavy accumulation of food debris along the electrical cable and in and around two electrical outlets.

According to staff interviewed, the floor, drains and air supply grilles have not been deep cleaned for several months.

Source: Housekeeping Manager, Dietary Manager, Director of Environmental Services, observations, various floor cleaning procedures. [s. 15. (2) (a)]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (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:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the air temperature was measured and documented in writing in various areas of the home, inlcuding two resident bedrooms in different parts of the home and a common area on every floor.

As confirmed by the Director of Environmental Services and the Director of Care, no air temperatures were being measured or monitored in the home since mid September, 2021.

Source: Staff interviews [s. 21. (2) 1.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented for cleaning and disinfection of contact surfaces and resident hygiene supplies or devices in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices.

A) Evidence-based practices for cleaning and disinfecting contact surfaces includes the

use of a disinfectant that has a Drug Identification Number (DIN) on the label. The DIN is an indicator that the product was approved by Health Canada for ensuring that labeling and supporting data have been provided and that it has undergone and passed a review of its formulation, labeling and instructions for use as a disinfectant.

According to records, the long-term care home had a respiratory outbreak from mid September to mid October, 2020. According to management staff, during this period, there was peak demand for ready-to-use disposable disinfecting wipes and it was difficult to obtain a specific type of product from some manufacturers. One of the licensee's suppliers suggested that they assemble their own disinfecting ready-to-use wipes using components from different manufacturers. The licensee therefore placed an order at the end of September for the supplies and began assembling their own disposable ready-to-use wipes thereafter. Their supplier provided the licensee with the supplies and the instructions on the assembly of the ready-to-use wipes, without first verifying that the instructions were compliant with the various manufacturers of the individual supplies. The licensee did not ensure that the final disinfectant product complied with individual manufacturer's specifications or that the final product was approved by Health Canada.

The process of assembling the ready-to-use wipes included taking a roll of dry wipes (from manufacturer #1 or #2), placing them into a small plastic bucket (from manufacturer #1), pouring in a specified amount of concentrated liquid disinfectant (from manufacturer #3) and letting the wipes absorb the liquid. The bucket was topped with a lid with a central slot, which allowed the wipe to be pulled through. Some of the buckets had two labels, one from manufacturer #3 with instructions on how to use the liquid disinfectant (not a wipe) and the second from manufacturer #1 about their dry wipes. Other buckets only had one label, from manufacturer #3. Once the bucket was empty, they were re-filled by housekeeping staff.

In creating the final product, the compatibility of the liquid disinfectant with the wipe, concentration of the disinfectant and subsequent shelf life was not known. Manufacturer #3, when they were informed about using their liquid disinfectant product with the dry wipes from other manufacturers, stated that their disinfectant was not compatible with other wipes, meaning that the wipes were not tested with their disinfectants and they could not guarantee that the active ingredients of the disinfectant were effective.

B) Evidence-based practices for cleaning and disinfecting non-critical items, which are resident hygiene supplies or devices such as bed pans, urinals, wash basins and other

re-useable plastic ware includes the use of a washer-disinfector machine or manual washing procedures that include cleaning (soaking the item, physical soil removal with soap and water, rinsing) and disinfection.

The licensee's policy on cleaning and disinfecting non-critical items reflected the evidence-based practices regarding the need to clean and disinfect these items with an approved disinfectant. The policy however did not include adequate information for staff on how to clean the wash basins, especially when they become highly soiled. Their policy included instructions to clean the reusable basin but not where (soiled utility room, shower room, resident washroom) or how (in a sink, machine) and with what supplies (cloth, brush, paper towel, liquid soap, specific disinfectant). The policy identified that once per week, the wash basins were to be disinfected in the hopper or if a hopper was not available, by soaking the item in disinfectant after cleaning. The direction is not in accordance with evidence-based practices as the hopper is not to be used for disinfecting any item. The hopper is the equivalent of a large toilet and is used to dispose of bodily fluids and rinsing soiled linens. Three personal support workers identified washing the basins in resident sinks with soap, water and a paper towel and the Director of Resident Care identified that wash basins were disinfected with a disposable disinfectant wipe once per week.

For commode pots and bed pans, the policy included cleaning and scrubbing the bed pan/commode pot in the hopper or a sink weekly followed by soaking in a disinfectant. No additional details were included. During the inspection, no supplies (brushes, liquid disinfectant, soap) or procedures were observed in neither of two soiled utility rooms located on two different floors. Shower chairs or commode chairs with pots had evidence of either bio-film, urine scale or water scale on the surface in shower rooms located on three different floors. Four personal support workers identified that they either had disinfectant wipes or a liquid disinfectant to use for cleaning/disinfecting the shower chairs along with the commode pots after use.

The licensee did not ensure that their policies and procedures were developed and implemented to ensure that resident hygiene supplies and contact surfaces were cleaned and disinfected using a low level disinfectant in accordance with manufacturer's specifications and evidence-based practices.

Source: Observations, staff interviews, Cleaning and Disinfection of Equipment (INR-03-02) Policy, Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment/Devices in All Health Care Settings, May 2013. [s. 87. (2) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were implemented to ensure that the temperature of the water serving hand basins used by residents was 49 degrees Celsius (C) or less.

The licensee's procedure for taking water temperatures required that staff take water temperatures in random resident accessible areas. Temperature logs maintained by both the maintenance staff and nursing staff were reviewed. The logs reviewed for the month of November included resident rooms and showers only and did not include any temperatures taken of the resident accessible hand sink in the activity room or either of the hand sinks located on either side of the servery on any floor.

The inspector measured the water temperature at the hand sinks on three different floors in the activity rooms. The water temperature was 49.3 C, 49.3 C and 49.8 C.

Source: Observations, staff interviews, Hot Water Temperature Monitoring (NPC-G-03) Policy. [s. 90. (2) (g)]

2. The licensee failed to ensure that procedures were implemented to ensure that the hot water serving showers and tubs were a minimum of 40 C.

According to water temperature records of the shower located on an identified home area, the water temperature was recorded to be below 40 C on 12 separate days, with no follow-up documentation noted. According to the licensee's procedure on monitoring water temperatures, the staff were required to inform the maintenance department and document the follow-up action. No records or calls were received by the maintenance department about the low water temperatures in November.

Source: Observations, staff interviews, Hot Water Temperature Monitoring (NPC-G-03) Policy. [s. 90. (2) (i)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that the designated staff member who co-ordinated the infection prevention and control program (IPAC) had education in infection prevention and control practices, including;

(a) infectious diseases;
(b) cleaning and disinfection;
(c) data collection and trend analysis;
(d) reporting protocols; and
(e) outbreak management

Education in IPAC includes taking courses in the above noted topics that are taught over the course of weeks or months followed by an examination process. The designated staff member identified they have reviewed approximately 7 on-line modules through Public Health Ontario, which are available to the general public and which are approximately 30 minutes each. The modules are not sufficient to provide the learner with theory in the above noted topics. The formal education is necessary to ensure that the designated lead will be able to assess, implement and/or oversee the implementation of an IPAC program in the home.

Source: IPAC Program Co-ordinator [s. 229. (3)]

Issued on this 14th day of December, 2021

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

Original report signed by the inspector.