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

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Original Public Report

Report Issue Date: November 4, 2022	
Inspection Number: 2022-1026-0001	
Inspection Type: Critical Incident System	
Licensee: Golden Years Nursing Homes (Cambridge) Inc.	
Long Term Care Home and City: Golden Years Nursing Home, Cambridge	
Lead Inspector Kristen Owen (741123)	**Inspector Digital Signature** Kristen A Owen Digitally signed by Kristen A Owen Date: 2022.11.08 13:21:50 -05'00'
Additional Inspector(s) Robert Spizzirri (705751)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s): October 31-November 3, 2022

The following intake(s) were inspected:

- Intake # 00003878, CI # 1033-000003-22, related to fall prevention, and management.
- Intake # 00005291, CI # 1033-000012-21, related to alleged neglect and improper continence care of residents.

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

Falls Prevention and Management
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

NON-COMPLIANCE REMEDIED

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O.Reg. 246/22, s. 93 (2) (b) (iii)

During the inspection, the Virox 5 Concentrated Surface Cleaner and Disinfectant that was currently being used to disinfect all frequently touched surfaces in the home, was observed in the housekeeping room with no expiry date. The home had additional stock of Virox 5 Concentrated Surface Cleaner and Disinfectant containers stored in the housekeeping room, all of which were observed to be expired.

When the home became aware of the expired disinfectants, new low-level disinfectants were received and used to disinfect frequently touched surfaces. The expired disinfectants were disposed of.

Sources: Inspector #741123's observations, Public Health Ontario (PHO) Provincial Infectious Diseases Advisory Committee (PIDAC), Best Practices for Environmental Cleaning for Prevention and Control of Infections in all Health Care Settings, 3rd Edition, April 2018, and interviews with staff.

Date Remedy Implemented: November 3, 2022

[741123]

WRITTEN NOTIFICATION: BINDING ON LICENSEES

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that where the Act required the licensee of a long-term care home to carry out every Minister's Directive that applies to the long-term care home, the Minister's Directive was complied with.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes (August 30, 2022), the licensee was required to ensure that the requirements for case and outbreak management as set out in the COVID-19 Guidance: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units (October 6, 2022) were followed.

The COVID-19 Guidance: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units (October 6, 2022) required the licensee to ensure that when a resident

requiring self-isolation is not able to be placed in a single room, other residents who reside with them must also be placed in self-isolation.

Rationale and Summary

A resident was isolated for suspected COVID-19. There was signage posted at the entrance of the resident's room, that indicated the additional precautions in place. The resident was in a shared room and had a roommate.

The resident's roommate was observed in the hallway with other residents, and later attended a meal service in the dining room.

A Registered Practical Nurse (RPN) said that the resident's roommate was not isolated.

The Infection Prevention and Control (IPAC) Manager said that residents who share a room with a resident suspected of COVID-19 must also be isolated because they are a high-risk contact.

Failure of staff to isolate a resident that is a high-risk contact as required, increased the risk of transmission and could have put other residents at risk of harm.

Sources: Minister's Directives: COVID-19 response measures for long-term care homes (August 30, 2022), COVID-19 Guidance: Long-Term Care Homes, Retirement Homes, and Other Congregate Living Settings for Public Health Units (October 6, 2022), and other documents, Residents' clinical health records, Inspector #705751's observations, and interviews with an RPN and the IPAC Manager.

[705751]

WRITTEN NOTIFICATION: CONTINENEC CARE AND BOWEL MANAGEMENT

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 51 (2) (g)

The licensee has failed to ensure residents who require continence care products have sufficient changes to remain clean, dry, and comfortable.

Rationale and Summary

On a morning in December 2021, 12 residents were found with their incontinence products, bed linen, and clothing saturated of urine and/or feces. Four of the residents were agitated, and one resident had damaged skin.

The licensee's investigation notes concluded that continence care was missed through the night.

The Executive Director said that a staff member was expected to assess the resident's need of continence care near the end of their night shift, however, this was not completed.

Failure to provide continence care to 12 residents left them uncomfortable and put them at risk of injury.

Sources: CI #1033-000012-21, Internal investigation notes and other documents, interview with executive director and other staff.

[705751]