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
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Original Public Report

Report Issue Date: October 25, 2023	
Inspection Number: 2023-1020-0005	
Inspection Type: Complaint	
Licensee: Sharon Farms & Enterprises Limited	
Long Term Care Home and City: Strathcona Long Term Care, Mount Forest	
Lead Inspector Bernadette Susnik (120)	**Inspector Digital Signature** Bernadette Susnik Digitally signed by Bernadette Susnik Date: 2023.11.09 14:04:48 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 27, 28, 2023
The inspection occurred offsite on the following date(s): September 29, 2023, and October 6, 20, 2023

The following intake(s) were inspected:

- Intake: #00092243 - Complaint re: elevator safety, staffing and sanitation in kitchen
- Intake: #00097292 - Complaint re: Elevator safety

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

Housekeeping, Laundry, and Maintenance Services

INSPECTION RESULTS

WRITTEN NOTIFICATION: Housekeeping

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (a) (ii)

The licensee has failed to ensure that as part of the organized program of housekeeping under clause 19 (1) (a) of the Act, procedures were developed and implemented for cleaning of the home, specifically the kitchen and the supply air vents/exhaust system components.

Rationale and Summary

A complaint was received in July 2023 that included concerns related to the lack of a Director of Dietary Services (DDS) and that a heavy coat of dust was on the ceiling around air supply vents located over food preparation areas. During the inspection, the dust had been removed from the air supply vents, however other issues were identified. This included mould accumulation in the walk-in cooler, excessive water scale build-up on equipment and the floor and build-up of visible matter on equipment surfaces. An excess amount of dust on and within the ceiling exhaust units was also observed in multiple tub and shower rooms.

A DDS had not been consistently available at the home for over a year and the position was recently filled in early August of 2023. Prior to their arrival, no monitoring, assessing, or auditing was being conducted to ensure that the sanitation of the kitchen was maintained.

Procedures were developed for the cleaning of exhaust fans (with no mention of supply air vents) for dietary service areas, resident washrooms, and other spaces and that they be checked routinely.

A cleaning and sanitizing policy was developed for food service areas which directed the DDS to ensure that cleaning schedules were developed and monitored for dishwashing areas including the non-food contact surfaces such as shelving, floors, walls, and ceiling. It also required that a visual inspection for cleanliness be performed daily by the DFS, or designate, at the end of the shift and at the end of the day. The cleaning schedule did not include the walls, doors, gasket, fan covers, or deep cleaning of the storage carts. It was limited to the floor and shelves. The daily cleaning schedule included that the dishwasher and the surrounding area be deep cleaned along with the sink areas. Cleaning of walls, vents, light covers, and ceiling tiles was not included.

Failure to develop and subsequently implement cleaning procedures and schedules has resulted in excess accumulation of both mould and dust.

Sources: Observations, review of food service cleaning and sanitizing procedure (DTY-027) and exhaust system cleaning procedure (FSM-C-140 Exhaust fans), kitchen cleaning schedules (September and October) interview with Director of Dietary Services, Director of Facility Services, dietary and housekeeping staff. [120]

WRITTEN NOTIFICATION: Maintenance services

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (1) (b)

As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, the licensee has failed to ensure that there were schedules and procedures in place for routine, preventive and remedial maintenance, specifically the elevator.

Rationale and Summary

Several complaints were received regarding one of three elevators in the home that were not functioning as intended beginning in July 2023.

The licensee's maintenance procedures and schedules did not include any reference to their elevators. Although the licensee had a preventive and remedial maintenance contract with an external elevator service provider (contractor) to inspect and repair the elevators on a routine basis, no additional information was available for the Director of Facility Services for the care and maintenance of the elevator. Information would include but not be limited to what specific tasks would need to be included on a daily basis to ensure that the elevator remains in good operating order and what course of action is necessary when issues are identified by any staff member.

Various staff members who used the elevators regularly reported to the inspector that they were jostled about within the cab of elevator #1 suddenly and that the issue would occur intermittently but continued to be ongoing. The sudden movement also caused staff members to drop food trays and glasses and other items on beverage carts fell over. During the inspection on September 28, 2023, the inspector was able to verify that the elevator was not operating properly. The incident was reported by the inspector to the administrator and to the Technical Standards and Safety Authority (TSSA). On October 2, 2023, a TSSA inspector visited the site followed by the elevator technician from the contracted service provider. After a thorough review, the root cause of the jolting was identified as excessive cab sway and adjustments made and components were replaced.

No service records were provided identifying what the cause was or what course of action was taken by the elevator technician who arrived on site on July 27, 2023, after a report was made that a staff member was trapped inside one of the elevator cabs.

Failure to have a procedure in place for preventive and remedial processes for the elevator, especially when the contractor is unable to diagnose on-going issues may lead to potential injuries to staff, visitors, and residents.

Sources: Review of maintenance policies and procedures, schedules, email correspondence, elevator maintenance records, interview with staff and non-staff and direct observation.
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