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 5, 2024

Inspection Number: 2024-1318-0003

Inspection Type:
Complaint
Critical Incident (CI)
Follow-up

Licensee: Regency LTC Operating Limited Partnership, by it general partners, Regency Operator GP Inc. and AgeCare Iris Management Ltd.

Long Term Care Home and City: AgeCare Wenleigh, Mississauga

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: October 8-11, 15-18, 22, 24-25, 28-29, 2024.

The following intakes were inspected:

- Intake #00118786 was a follow-up related to transferring and positioning techniques
- Intake #00118787 was a follow-up related to plan of care
- Intake #00120793/ CI 2833-000014-24 was related to falls prevention and management
- Intake #00120893/ CI 2833-000015-24 was related to outbreak management
- Intake #00127600 was related to concerns with continence care, dining and environmental services

The following intakes were completed in this inspection:

- Intake #00117659/ CI 2833-000011-24 was related to falls prevention and management
- Intake #00117213/ CI 2833-000010-24 & Intake #00120317/ CI 2833-000013-24 were related to outbreak management

Previously Issued Compliance Orders

The following previously issued Compliance Orders were found to be in compliance:

Order #002 from Inspection #2024-1318-0002 related to O. Reg. 246/22, s. 40
Order #001 from Inspection #2024-1318-0002 related to FLTCA, 2021, s. 6 (7)

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

Resident Care and Support Services
Continence Care
Food, Nutrition and Hydration
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Accommodation Services

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (1) (b)

Accommodation services
s. 19 (1) Every licensee of a long-term care home shall ensure that,
(b) there is an organized program of laundry services for the home to meet the linen and personal clothing needs of the residents; and

The licensee failed to ensure the organized program of laundry services for the home was complied with. In accordance with Ontario Regulation (O. Reg.) 246/22 s. 11 (1) (b), the licensee was required to ensure the laundry services program met the linen needs of the residents. Specifically, staff failed to comply with a linen inventory count policy within the laundry services program

Rationale and Summary
Observations of linen supply were conducted at the clean linen restock carts, care supply carts and in multiple resident rooms. When the clean linen restock carts were prepared to be taken to the resident home areas (RHA) for afternoon and evening care, the available quantities did not meet the quotas to be stocked per cart. There was limited supply of face cloths stocked in resident rooms and care supply carts on a specified unit.

Staff indicated they regularly go to the laundry room on each shift to retrieve sufficient supply of towels, mainly bath towels and face cloths, to complete care activities. No instances of missed care or alternatives to towels being used were noted by staff. Multiple residents acknowledged that if they ask for a specific towel, staff are usually able to provide one.

Long-term care home (LTCH) management indicated a process for counting linen inventory throughout the home as directed by the home's policies had not been implemented in order to monitor for deficiencies between available stock per RHA and calculated quotas.

Failure for the LTCH management team to implement a linen inventory count process may lead to potential deficiencies within the home's linen supply going undetected.

Sources: Observations of linens supply throughout the LTCH, residents' council meeting minutes and complaints forms, linen inventory count policy, interview with LTCH management, staff and residents.

WRITTEN NOTIFICATION: Windows

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee failed to ensure every window in the home that opened to the outdoors and was accessible to residents had a screen.

Rationale and Summary
Multiple windows in resident common areas which opened to the outdoors were identified without screens. LTCH management acknowledged that the observed windows did not have screens installed.

Failure to ensure multiple windows that opened to the outdoors had screens installed increased the risk of pests entering into the LTCH.

Sources: LTCH observations, interview with LTCH management.

WRITTEN NOTIFICATION: Continence Care and Bowel Management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (1) 5.
Continence care and bowel management
s. 56 (1) The continence care and bowel management program must, at a minimum, provide for the following:
5. Annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated.

The licensee failed to ensure a process was in place to consult direct care staff regarding the annual evaluation of residents' satisfaction with the range of continence care products.

Rationale and Summary
The LTCH management team reviewed residents' satisfaction with the range of continence care products as part of their annual continence care program evaluation. There was no process in place to consult with direct care staff as part of the annual evaluation of residents' satisfaction with continence care products.

Failure to consult direct care staff as part of the annual continence care product satisfaction evaluation may have led to gaps in the product feedback received by the LTCH.

Sources: Annual continence care program evaluation, interviews with LTCH management.

WRITTEN NOTIFICATION: Housekeeping

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (a) (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,
(a) cleaning of the home, including,
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

The licensee failed to ensure 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, including common areas, specifically, contact surfaces and wall surfaces.

Rationale and Summary
Multiple dining rooms were observed and surfaces throughout both dining rooms were noted to have areas of visible soil, streaks, dried food and fingerprints. The main dining room door surfaces, door handles, key pads, walls, chair legs, decorative moulding and wall surfaces nearby the servery were observed to be soiled. Staff expressed concern with the frequency at which wall and chair surface cleaning in the dining rooms was being completed, indicating cleaning tasks were being completed less frequently resulting in an increase in soil build-up on surfaces. The home's deep cleaning policy required the LTCH management to develop and

maintain rotating deep cleaning routines of all common areas to maintain appeal, sanitation and pest prevention. The routine for deep cleaning the dining room outlined the following duties pertaining to the above-specified dining room surfaces: walls and doors were to be spot washed daily and thoroughly cleaned with disinfectant cleaner monthly. The routine did not outline a duty for cleaning the legs of the dining room chairs. It was unclear whether dietary aides or housekeeping staff were to carry out specified duties within the routine for deep cleaning the dining room. LTCH management acknowledged that the surfaces observed in the third floor dining rooms did not demonstrate hotel-level cleanliness, which may result in difficulty achieving hospital-level cleanliness through monthly disinfection.

Management also acknowledged that their written cleaning schedule did not include deep cleaning of the dining room. They provided verbal direction to the assigned housekeepers on a monthly basis regarding their assignments for their shift. Further, they confirmed that two dining rooms received a deep clean per month over the last three months, which did not follow the guideline where each dining room was to receive specified cleaning and disinfection on a daily or monthly basis.

Failure to maintain cleanliness of the above-specified surfaces in the dining rooms throughout the LTCH prevented them from being cleaned and disinfected properly. The condition and appearance of the surfaces may influence the level of pleasure a resident has within their dining space.

Sources: Observations and images taken of specified dining rooms, Health & Safety Committee meeting and inspection minutes, dining room deep cleaning sign-off sheets, housekeeper and dietary aide job duties, sanitation and safety inspection guide support tool, deep cleaning, disinfection and housekeeping protocol policies, housekeeping program, interviews with LTCH management and other staff.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes was implemented.

Rationale and Summary
A) The IPAC Standard required under section 4.3 that following the resolution of an outbreak, a debrief session was to be conducted to assess IPAC practices that were effective and ineffective in the management of the outbreak. A summary of findings was to be used to make recommendations to the licensee for improvements to outbreak management practices.

The LTCH declared an outbreak in July 2024. Following the outbreak, a debrief meeting was held, which identified an area for improvement based on the review of the outbreak. The IPAC Lead acknowledged that a specified individual was considered the representative of the licensee and they were not sent the outbreak debrief or summary of recommendations for improvements to outbreak management practices.

Failure to provide a summary of findings, including areas for improvement, to the licensee may have led to missed opportunities for support or resource allocation

related to the identified gaps.

Sources: Outbreak debrief meeting minutes, CI 2833-000015-24, IPAC Standard, interview with the IPAC Lead.

B) The IPAC Standard required under section 6.1 that personal protective equipment (PPE) was to be available and accessible to staff, appropriate to their role and level of risk.

An empty door-mounted PPE caddy was observed on a resident door. Registered nursing staff confirmed additional precautions were in place for the resident and their PPE had been removed from the caddy. The IPAC Lead confirmed that PPE supply was to be available outside the resident's room.

Failure to ensure PPE was available at point-of-care increased the risk of improper or absent PPE use by staff during care when additional precautions were in place for the resident.

Sources: Resident room observations, resident clinical record, routine practices and additional precaution policy, IPAC Standard, interviews with IPAC Lead and other staff.

C) The IPAC Standard required under section 9.1 that additional precautions were to at minimum include e) point-of-care signage indicating that enhanced IPAC control measures were in place.

An empty door-mounted PPE caddy was observed on a resident's door, with no point-of-care signage present on the door or in the resident's room. Direct care staff were unsure whether the resident had additional precautions in place or which PPE

was to be worn when providing care. Registered nursing staff confirmed additional precautions were in place for the resident; however, the signage had been removed from the doorway. The IPAC Lead confirmed IPAC precaution signage was to be in place at the resident's room doorway.

Failure to ensure point-of-care signage was in place to notify staff of enhanced IPAC control measures in place for the resident led to uncertainty about the precautions in place and PPE required for care.

Sources: Resident room observations, resident clinical record, routine practices and additional precautions policy, IPAC Standard, interviews with IPAC Lead and other staff.