Ontario

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

Inspection Report Under the Fixing Long-Term Care Act, 2021

Hamilton District
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Original Public Report

Report Issue Date: January 3, 2023	
Inspection Number: 2022-1432-0003	
Inspection Type: Complaint	
Licensee: 955464 Ontario Limited	
Long Term Care Home and City: Millennium Trail Manor, Niagara Falls	
Lead Inspector Bernadette Susnik (120)	**Inspector Digital Signature** Bernadette Susnik Digitally signed by Bernadette Susnik Date: 2023.01.09 12:28:25 -05'00'
Additional Inspector(s) Kwesi Douglas (736409)	

INSPECTION SUMMARY

The Inspection occurred on the following dates:

December 6-8, 2022 (on-site)
December 9, 12, 16, 2022 (off-site)

The following intake(s) were inspected:

Intake #00011350 and #00011351 were related to maintenance services and doors in the home.

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

- Housekeeping, Laundry, and Maintenance Services
- Infection Prevention and Control
- Safe and Secure Home

INSPECTION RESULTS

During the course of this inspection, the inspector(s) made relevant observations, reviewed records, and conducted interviews, as applicable. There were *findings of non-compliance.*

WRITTEN NOTIFICATION [HOUSEKEEPING]

NC#01 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s. 93 (2)(b)(ii)

As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee failed to ensure that procedures were developed and implemented for cleaning and disinfection of devices in accordance with manufacturer's specifications and using a low-level disinfectant in accordance with evidence-based practices.

The Director of Care (DOC) provided Conmed policy CIC-02-26 (Dec. 9/2020) titled "Cleaning and Disinfection" related to processing non-critical equipment (devices). The policy included the requirement for staff to clean devices with soap and water, detergents or disinfectant wipes followed by disinfecting with disinfectant wipes. No information was included about where to clean the devices with soap, water, or detergents (soiled utility room, which sink) or when (after use). No information was included about using the disinfection machine (where one was available), and no contingency plan should one or both machines fail. The policy and procedure were not reflective of the equipment in the home.

A night shift routine that was provided for the Stamford home area, included written directions for personal support workers to stock resident room with disinfectant wipes and other supplies. PSWs were to use the Ninjo's (a disinfection machine) once per week to wash bed pans, urinals and washbasins. The Stamford home area did not have a disinfection machine in their soiled utility room.

During a tour of the home, two disinfection machines were observed, one in the Elgin soiled utility room on 2nd floor and one in the Chippewa soiled utility room on the third floor. None of the soiled utility rooms were equipped with any utility sinks for cleaning and disinfection purposes (where a machine was not provided) or included any cleaning and disinfection supplies or products for the purpose.

In many resident rooms, bed pans were stored inappropriately on grab bars along with PPE supplies such as gloves. In an identified resident washroom, a bed pan was stored on the grab bar of a shared washroom that was visibly soiled with the appearance of feces for several shifts. No disinfection or cleaning supplies were noted in or around resident rooms.

Two different PSWs reported that wash basins were typically rinsed and placed on top of a cabinet in the resident's bathroom after use. No disinfection process was used. One PSW reported that they used shampoo gel to wash the basin after use and did not use any type of disinfectant product afterward.

According to the Director of Nursing Operations, new procedures from Extendicare were acquired in September 2022, which were being transitioned for use by Conmed staff. The DOC was not aware that not all soiled utility rooms had a disinfection machine and did not know specifically how personal support workers were cleaning and disinfecting non-critical items between use. The IPAC lead position was vacant since the last week of October 2022.

Sources: Interviews with the Director of Care, Director of Nursing Operations, personal support workers, policy and procedure review and observations.

[120, 736409]

WRITTEN NOTIFICATION [LIGHTING]

NC#02 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22, s.21. 2. v

The licensee failed to ensure that the lighting was maintained in accordance with the following requirement: all other areas shall have lighting with minimum levels of 215.28 lux.

The dining rooms and lounges in each resident home area were observed to have less than the required number of bulbs in the round ceiling light fixtures installed. Most fixtures included 2 bulbs instead of the 4 required. The lack of bulbs reduced the amount of light emitted.

Dining rooms specifically were measured. Each dining room had a few tables situated under bulkheads, further lowering the lux levels over the tables. Light levels were measured by the inspectors during the inspection and noted to be as follows:

Clifton RHA Dining Room
Over table #3 - 135 lux (table under bulkhead)
Over table #4 - 198 lux (table under bulkhead)
Over table #6 -169 lux

Elgin RHA Dining Room
Over table #1 - 85 lux

The Montrose common resident washroom did not have a lighting fixture in the middle of the room as other similar washrooms. The light fixture was instead positioned along one wall, near the toilet. The hand wash sink was therefore in semi darkness and the lighting level was measured to be 100-190 lux.

According to the Director of Environmental Services, the bulbs were in short supply over the last few years and no plans were in place to replace them. Instead, a proposal was conveyed to the inspectors that the round light fixtures would be replaced with different fixtures that did not require the continuous replacement of bulbs.

Sources: Interviews with the Director of Environmental Services, the Administrator, direct observation, and measurements.

[736409, 120]

COMPLIANCE ORDER [CO #01] [DOORS IN A HOME]

NC#03 Compliance Order pursuant to FLTCA, 2021, s.154(1)2

Non-compliance with: O. Reg. 246/22, s. 12 (1) (3)

Compliance Plan [*FLTCA, 2021, s. 155 (1) (b)*]

Specifically, the licensee shall prepare, submit, and implement a plan that identifies how all doors to non-resident areas (utility, housekeeping, garbage chute, linen chute, and mechanical rooms) are latched and locked at all times.

The plan must include but is not limited to:

- The measures that will be implemented immediately to ensure doors to non-resident areas are latched and locked at all times;
- A proposal as to what work, if any, will be completed to the doors or door hardware to ensure they function as intended;
- Who will do the work;
- An approximate timeframe for the above work; and
- Who will be responsible and the frequency for verifying that all doors and door hardware are functioning as intended.

Please submit the written plan for achieving compliance for inspection [#2022-1432-0003] to Bernadette Susnik, LTC Consultant and Environmental Inspector, MLTC, by email to Hamiltondistrict@mltc@ontario.ca by January 9, 2023.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds

The licensee has failed to ensure that all doors leading to non-residential areas, specifically garbage and linen chute rooms, housekeeping and mechanical/equipment storage rooms were kept closed and locked when they were not being supervised by staff.

The Clifton laundry chute room, clean utility, housekeeping closet, mechanical room, Elgin garbage chute room, and Chippewa laundry chute room doors were pushed open as they were not latched. Doors were tested by pushing them open and letting them self-close to determine if they would latch, and lock automatically as intended. All were connected to self-closing device hardware.

The Montrose mechanical room door was closed but unlocked.

Keys were left in the Clifton garbage chute room door during the inspection. No staff claimed the keys for over 1/2 hour and inspector #120 removed them and returned them to the registered practical nurse on duty.

Elgin balcony (mid corridor location) door locking mechanism was not functioning as intended. Once locked with a key and pulled closed, the door could still be pushed open. The door had to be pulled very hard to get the mechanism to lock.

The observations were conveyed to the Director of Environmental Services (DES) who stated that the self-closing devices had been previously adjusted after a previous inspection (in July 2022) to ensure that the doors latched and locked. However, it was discovered by the DES that the tension of the self-closing hardware would change once the doors were knocked with equipment or handled roughly. The DES explained that the doors were not solid core doors and were more flexible, creating the condition.

Sources: Interview with Director of Environmental Services, observations and testing of the doors.

[120, 736409]

This order must be complied with by January 31, 2023

COMPLIANCE ORDER [CO #02] [SPECIFIC DUTIES RE REPAIR]

NC#04 Compliance Order pursuant to FLTCA, 2021, s.154(1)2

Non-compliance with: FLTCA, 2021, s. 19 (2)(c)

The Inspector is Ordering the licensee to *[FLTCA s. 155 (1) (a)]*:

- Address the specific maintenance deficiencies identified in the grounds below;
- Conduct an audit or inspection of the home using an audit form or checklist to determine what other deficiencies require attention that have not been identified in the grounds below;
- Provide the inspector with a schedule that includes which persons will be responsible for addressing the maintenance deficiencies in the grounds below and the time that will be allocated to completing the work; and
- Provide the inspector with a plan as to how the licensee intends to ensure that the home has adequate maintenance hours to ensure that the home, furnishings, and equipment will be maintained in a safe condition and a good state of repair.

Please submit the written plan for achieving compliance for inspection [#2022-1432-0003] to Bernadette Susnik, LTC Consultant and Environmental Inspector, MLTC, by email to Hamiltondistrict@mltc@ontario.ca by January 20, 2023.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds

The licensee has failed to ensure that the home, furnishings, and equipment were maintained in a safe condition and in a good state of repair.

- Clean utility rooms were originally designed and approved to include hand wash sinks. These sinks were either missing entirely or not hooked-up to running water during the inspection.
- The servery on the third floor had a large hole in the wall under the rinse area of the dish machine and the kitchen had a large hole behind the dish machine.
- Flooring material was not tight-fitting and easy to clean as it was split apart in the Stamford soiled utility room, in the Stamford dining room (in front of servery) and inside of the servery, Clifton tub room and Clifton shower area.

- The surface of most of the dining room tables in each resident home area were peeled down to an absorbent layer.
- The ceiling surface over the dishwasher in the third-floor servery was peeling and water stained, the surface on the bulkhead near the Montrose servery and two areas of the Montrose lounge were not finished after repairs or water leaks. The ceiling material over the Stamford shower cabinet was water damaged and had an appearance of some mould growth on the ceiling.
- Cabinetry doors located in nurse's stations in each home area were not adjusted to prevent the door from grinding into the floor when opened. The cabinetry located next to each shower cabinet in each home area was water damaged, with frayed edges and peeling laminate. The cabinet under the sink in the Stamford servery was water damaged.
- Water-stained ceilings noted in numerous resident washrooms, in the Clifton resident common washroom and staff washroom.
- Ceiling lift equipment was not functional in 6 resident rooms. Records provided indicated they had not been functional since June 2022.
- Windows throughout the home were difficult to slide open or closed (not lubricated).
- Faucet and taps were very loosely attached to the sink counter in the Stamford servery and Stamford nursing station sinks.
- The wood paneling in front of the serveries (facing the dining rooms) on 2nd and 3rd floors were absorbent, and the sealant appeared to have been worn away.
- The surface of a wall in the Stamford housekeeping closet had damage from an old water leak and was not cleanable.
- Most of the shower handles for the shower cabins were leaking when tested.

According to the Director of Environmental Services (DES), a flooring replacement program was underway, but a specific timeline for completion was not provided. The DES was aware of some deficiencies but not all based on what was reported to their department via a software program by staff from different departments. If staff did not complete a maintenance request in the staff accessible software program, the DES was not aware of the deficiency.

According to the Director of Housekeeping for Sunshine Building Maintenance Inc, housekeeping staff were required to complete a checklist when cleaning various spaces within the home when deficiencies were identified related to furnishings, surfaces, fixtures, cabinetry, plumbing, etc. The notations were subsequently transferred to the maintenance software program by the housekeeping manager.

The Nutrition Manager verified that they were aware of and used the maintenance software program to report deficiencies in the serveries, kitchen, and dining rooms.

Conmed maintenance work routine procedure CE-02-04-2 included a list of surfaces (doors, walls, ceilings, floors), furnishings, plumbing, fixtures, and equipment that were to be inspected monthly for maintenance condition. Based on the observations, it did not appear that the monthly inspections were implemented.

According to the Director of Care and documentation provided, personal support workers used a checklist to document the condition of ceiling lifts and floor lifts prior to use. Based on the documentation, many ceiling lifts were identified to be non-functional in June, 2022. The DES was unaware of the condition of the ceiling lifts in particular, as the information was not conveyed to them or was entered into the maintenance software program. They reported that a former employee and the Associate Director of Care were responsible for ensuring that the lift equipment was maintained in good condition and reporting any deficiencies to the DES when necessary.

Sources: Observations, review of Conmed maintenance procedures, PSW ceiling and floor lift start-up checklists, interview with the Director of Environmental Services, Director of Care, and Director of Housekeeping for Sunshine Building Maintenance Inc.

[120, 736409]

This order must be complied with by March 31, 2023

COMPLIANCE ORDER [CO #03] [RESIDENT-STAFF COMMUNICATION & RESPONSE SYSTEM]

NC#05 Compliance Order pursuant to FLTCA, 2021, s.154(1)2

Non-compliance with: O. Reg. 246/22, s. 20 (f)

Compliance Plan [*FLTCA, 2021, s. 155 (1) (b)*]

Specifically, the licensee shall prepare, submit, and implement a plan to ensure that the resident-staff communication and response system (RSCRS) functions as intended.

The plan must include but is not limited to:

- The measures that will be implemented in the short-term to ensure staff who are required to respond to activated stations will do so in a timely manner;
- A proposal of how the current RSCRS will be enhanced or altered so that staff are able to respond to all calls both visually and audibly; and
- The person who will be responsible for monitoring the RSCRS for function and the frequency of said monitoring.

Please submit the written plan for achieving compliance for inspection [#2022-1432-0003] to Bernadette Susnik, LTC Consultant and Environmental Inspector, MLTC, by email to Hamiltondistrict@mltc@ontario.ca by January 9, 2023.

Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds

The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system (RSCRS) that clearly indicated when activated where the signal was coming from.

The home's RSCRS was originally designed and approved to work in conjunction with pagers which were to be carried by all direct care staff. This would ensure that regardless of where staff were working, they would be alerted (both visually and audibly) to the location of an activated station. During the inspection, on all three days, multiple personal support workers (PSWs) in all home areas were not carrying a pager. Where PSWs provided a pager to the inspectors for a function test, the pagers did not function. The PSWs identified that the pager they were required to carry was not functional.

The home's RSCRS was not clearly indicating to staff where the signal was coming from. The PSWs reported that in order to determine where the signal originated, they had to walk around the home area looking at dome lights (if lit) or walk to the nursing station and look at a desk console display screen to see the room number or stairwell exit door location. A desk console was noted on the nursing desk in each home area, except for Stamford, which was in the Registered Nurse's office and was unplugged. The desk consoles emitted a sound, but generally could not be heard around the corner from the desk area. Therefore, PSWs did not know and would not know if a resident or staff member required assistance when working in any part of the home that was not near the nurse's station.

The Director of Nursing Operations was aware of the RSCRS not being fully operational and identified that plans were being initiated to add digital marquees to the home areas as a substitute for the pagers. However, the plan had not been submitted to the Ministry of Long-Term Care for approval as the system would be amended from it's originally approved design.

Sources: Interview with the Director of Environmental Services, Director of Nursing Operations, personal support workers, observations.

[120, 736409]

This order must be complied with by January 31, 2023

COMPLIANCE ORDER [CO #04] [HOUSEKEEPING]

NC#06 Compliance Order pursuant to FLTCA, 2021, s.154(1)2

Non-compliance with: O. Reg. 246/22, 93 (2) (a)

The Inspector is Ordering the licensee to *[FLTCA s. 155 (1) (a)]***:**

- Thoroughly clean the following in the serveries: interior of all cabinetry, the exterior surfaces of dishwashing machines, exterior of all refrigerators, the floor and baseboards, the floor under and beside the steam tables, and cart wheels;
- Thoroughly clean the Stamford garbage chute room floor and remove the dust from the vents in the Stamford and Clifton garbage chute rooms, and from the ceiling and vent in the Clifton nursing station;
- Develop and implement a deep cleaning schedule for all serveries that allocates adequate housekeeping hours to deep clean floors, surfaces (walls, ceilings, cabinets, and interior shelving), carts, dishwashing equipment and other equipment that includes a frequency that is dependent on the needs and outcomes of the activities that take place in each servery; and
- Develop and implement a housekeeping audit that requires a manager to review the level of sanitation in all serveries and utility rooms on a weekly basis.

Grounds

The licensee has failed to ensure that as part of the organized program of housekeeping under clause 19 (1) (a) of the Act, that procedures were implemented

for cleaning of the home, specifically the serveries and utility rooms.

All serveries were noted to have accumulated debris under the steam tables, scale on exterior surfaces of dishwash machines, visible accumulation of debris in corners (near steam table), visible soiling of flooring and baseboards, visible soiling of refrigerator surfaces (vent area), carts (wheels), interior of cabinets (shelving) and other surfaces.

Heavily soiled floor in the garbage chute room and very thick dust on the exhaust vent in the laundry chute room in the Stamford home area was observed.

Accumulation of dust on the ceiling in nurse's station in Clifton and on a vent in the Clifton garbage chute room was observed.

According to the cleaning schedule for all serveries, cabinets, equipment, flooring, carts, and other surfaces were required to be cleaned after each use or daily. Floors were required to be deep cleaned once per month. The level of sanitation was not reflective of what staff identified as cleaned on the schedule. The floor cleaning frequency did not appear adequate for the amount of accumulation that was seen in the serveries.

According to the procedure for cleaning the chute rooms (dated December 2022), staff were to clean the floors as needed, however based on observations, it did not appear that housekeeping staff were following the procedure.

Sources: Direct observation, review of cleaning procedures and schedules, interview with the Administrator, Nutrition Manager, Director of Housekeeping for Sunshine Building Maintenance Inc., and Director of Environmental Services.

[120, 736409]

This order must be complied with by January 13, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the *Fixing Long-Term Care Act, 2021* (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB).

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include,

(a) the portions of the order or AMP in respect of which the review is requested. Please include the inspection report # and the order or AMP #;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.
The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director

c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON M7A 1N3
email: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- registered mail, is deemed to be made on the fifth day after the day of mailing
- email, is deemed to be made on the following day, if the document was served after 4 p.m.
- commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- An order made by the Director under sections 155 to 159 of the Act.
- An AMP issued by the Director under section 158 of the Act.
- The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board	**Director**
Attention Registrar	c/o Appeals Coordinator
151 Bloor Street West,9th Floor	Long-Term Care Inspections Branch Ministry of Long-Term Care
Toronto, ON M5S 1S4	438 University Avenue, 8th Floor Toronto, ON M7A 1N3 email: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.