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

Hamilton District
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Modified Public Report (M)

Report Issue Date: July 24, 2023	
Inspection Number: 2023-1432-0005	
Inspection Type: Follow up	
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: 2023.07.24 09:06:30 -04'00'
Additional Inspector(s)	

MODIFIED INSPECTION SUMMARY

This public inspection report has been modified. Non-compliance (NC) #003 did not include the notice of administrative monetary penalty (AMP) statement on the original public report. It has now been added.

The inspection occurred onsite on the following date(s): April 24, 25, 2023 and May 2, 3, 2023
The inspection occurred offsite on the following date(s): May 4, 5, 9, 11, 12, 2023

The following intake(s) were inspected:

- Intake: #00018650 - Follow-up to Compliance Order (CO) #001 from inspection #2022-1432-0003 regarding s. 12 (1) 3 under O. Reg. 246/22 with a Compliance Due Date (CDD) of January 31, 2023
- Intake: #00018651 – Follow-up to CO #002 from inspection #2022-1432-0003 regarding s. 19 (2) (c) under the FLTCA, 2021 with a CDD of March 31, 2023.
- Intake: #00018649 - Follow-up to CO #003 from inspection #2022-1432-0003 regarding s. 20 (f) under O. Reg. 246/22 with a CDD of January 31, 2023.
- Intake: #00018648 - Follow-up to CO #004 from inspection #2022-1432-2022 regarding s. 93 (2) (a) under O. Reg. 246/22 with a CDD of January 13, 2023

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #003 from Inspection #2022-1432-0003 related to s. 20 (f) under O. Reg. 246/22, inspected by Bernadette Susnik (120)

The following previously issued Compliance Order(s) were found **NOT** to be in compliance:

Order #001 from Inspection #2022-1432-0003 related s. 12 (1) 3 under O. Reg. 246/22, inspected by Bernadette Susnik (120)

Order #002 from Inspection #2022-1432-0003 related to s. 19 (2) (c) under FLTCA, 2021, inspected by Bernadette Susnik (120)

Order #004 from Inspection #2022-1432-0003 related to s. 93 (2) (a) under O. Reg. 246/22, inspected by Bernadette Susnik (120)

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Licensee must comply - Housekeeping

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)

The licensee has failed to comply with the conditions of Compliance Order (CO) #004 from inspection #2022-1432-0003 related to housekeeping under s. 93 (2) (a) of O. Regulation 246/22 served on January 4, 2023, with a compliance due date of January 31, 2023.

Specifically, the licensee failed to comply with a), (b) and c) below;

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.

b) 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.
c) 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.

During the follow-up inspection, the serveries were noted to have accumulated debris under the steam tables, refrigeration units, visible accumulation of debris in corners (near steam table), visible soiling of flooring, walls and baseboards, visible soiling of lower refrigerator surfaces, carts (wheels), dishwashers, interior and exterior cabinet surfaces and some of the ceilings were spotted with stains.

Floor cleaning in the serveries using a floor scrubber had not occurred since mid-January 2023.

Some of the specific exhaust vents noted in the previous inspection were cleaned of excessive dust, however accumulated and heavy amounts of dust were noted on exhaust vents in the Clifton garbage chute room, Clifton tub and shower rooms (noted over an 8-day period), Montrose laundry chute room, Stamford laundry chute, Stamford environmental room and there was accumulated loose debris on the floor in the Chippewa environmental room.

The licensee's deep cleaning and routine cleaning frequencies had not been either implemented, amended, or altered since the previous inspection.

Sources: Direct observation, review of housekeeping procedures and schedules, interview with Housekeeping Supervisor, and Director of Environmental Services. [120]

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #001
Related to Written Notification NC #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

This is the first time the licensee has failed to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice. Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

WRITTEN NOTIFICATION: Licensee must comply - Maintenance

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)

The licensee has failed to comply with the conditions of Compliance Order (CO) #002 from inspection #2022-1432-0003 related to maintenance services under s. 19 (2) (c) of the Fixing Long-Term Care Act (FLTCA), 2021 served on January 4, 2023, with a compliance due date of March 31, 2023.

Specifically, the licensee failed to comply with a), b) and c) below:

a) Address the specific maintenance deficiencies identified in the grounds below;

1. 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.

2. The surface of most of the dining room tables in each resident home area were peeled down to an absorbent layer.

3. Windows throughout the home were difficult to slide open or closed (not lubricated).

b) 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 specified in the inspection report.

c) 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.

During the inspection, the dining room tables remained outstanding as the surface of most of the dining room tables in each resident home area had patches that were peeled down to an absorbent layer and had paper stuck to the laminate surface. The status of the double hung sliding windows throughout the home continued to be stiff and very difficult to slide open or closed or to latch and lock during the inspection. The status of the flooring in the Stamford dining room and soiled utility room remained outstanding.

No results from an audit or inspection of the home were provided for review during the follow-up inspection. 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 was not submitted for review during the follow-up inspection.

Sources: Direct observation, review of maintenance policies and procedures, interview with the Administrator, and Director of Environmental Services. [120]

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #002

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #002
Related to Written Notification NC #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

This is the first time the licensee has failed to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice. Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

WRITTEN NOTIFICATION: Licensee must comply - Doors in a home

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)

The licensee has failed to comply with the conditions of Compliance Order (CO) #001 from inspection #2022-1432-0003 related to non-resident doors under s. 12 (1) 3. of O. Regulation 246/22, served on January 4, 2023, with a compliance due date of January 31, 2023.

Specifically, the licensee failed to comply with the requirements noted below:

• 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.

Based on a tour that was conducted of all 5 home areas during the inspection, the same doors as previously identified to non-resident areas (employee utility and storage rooms) were found to be unlatched and therefore unlocked. When the doors were fully retracted and let go, the door's latch bolt did not engage with the opening of the striker plate. The unlatched doors included laundry and garbage chute rooms, environmental rooms, soiled utility rooms in the Clifton, Elgin, and Montrose home areas as well as the main floor.

The licensee did not identify what work specifically was completed other than to identify the doors were "fixed". Interviews with maintenance staff during the follow-up inspection identified that the self-closing devices on the doors were adjusted since the prior inspection. As to who was responsible for verifying that all doors and door hardware was functioning as intended, the licensee's response included that staff were to report when the doors or door hardware were not functioning as intended by using their maintenance request software program. The licensee's maintenance request software only included 4 door and lock issues identified by staff since January 1, 2023.

The Director of Care was not aware of the fact that the doors were being left unlatched by staff and she and the Administrator had not implemented any other action to ensure that they were.

Sources: Interview with the Administrator, Director of Care, Director of Environmental Services, direct observations and testing of the doors. [120]

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021
Notice of Administrative Monetary Penalty AMP #003
Related to Written Notification NC #003

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $1100.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

This is the first time the licensee has failed to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice. Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

WRITTEN NOTIFICATION: Air Temperatures

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (5)

The licensee failed to keep a record of the measurements documented under subsections (2), (3) and (4) for at least one year.

Rationale and Summary

Year-round temperature records could not be provided when requested between June 2022 and end of April 2023. Only six days of records could be provided for May and June of 2022.

Sources: Interviews with the Director of Environmental Services (DES), administrator, registered staff, review of air temperature logs, and air temperature policies and procedures. [120]

WRITTEN NOTIFICATION: Housekeeping

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (a) (ii)

The licensee failed to ensure that as part of the organized program of housekeeping under clause 19 (1) (a) of the Act, that procedures were developed and implemented for, cleaning of the home, including floors, carpets, and wall surfaces in common areas and staff areas.

Rationale and Summary

The following was observed during the inspection:

- The Chippewa tub and shower room floors, and the flooring in the corridor leading to these rooms was visibly soiled from April 24 to May 3, 2023. The floor had black streaks in the middle of the floor near the tub and dark areas along path of travel, baseboards and around the tub. Housekeeping procedures for cleaning tub and shower rooms included a task to wash floors daily with mop and bucket, but no reference to any deep cleaning. A policy titled “Floors” identified that floors were to be washed using a scrubber (floor machine), daily, weekly, and quarterly, but did not identify what locations this task would apply to.
- Outdoor areas such as main entrance was littered with cigarette buts on four different days. Some balconies (especially Montrose and Chippewa) had bird nesting materials, bird feces and debris on the floor and these were regularly used by residents. No housekeeping cleaning procedures were developed to address how frequently or who will monitor or clean these areas.
- Black soot accumulation observed on 3 separate resident bedroom ceilings in line with the air supply grille. No housekeeping cleaning procedures were developed to address this issue.
- Visible matter was noted on carpeting in the Montrose lounge for over 7 days and only cleaned when raised with the Site Supervisor. Carpeting in the stairwells was visibly discoloured (black) from foot traffic and had not been deep cleaned in December 2022 when it was last scheduled. According to the Housekeeping Supervisor, carpets were scheduled for twice per year deep cleaning and spot cleaned when needed. No housekeeping procedure was developed for carpet care or the need to clean stairwells.

Sources: Direct observation, review of housekeeping cleaning procedures and schedules, interview with the Housekeeping Supervisor, and Director of Environmental Services. [120]

WRITTEN NOTIFICATION: Laundry Service

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 95 (1) (b)

As part of the organized program of laundry services under clause 19 (1) (b) of the Act, the licensee failed to ensure that procedures were developed and implemented to ensure that a sufficient supply of clean linen, face cloths and bath towels was always available in the home for use by residents.

Rationale and Summary

Observations over four separate days of several resident home areas revealed an insufficient quantity of face cloths hand towels and bath towels. According to the Housekeeping Supervisor, each home area was to receive 3 sets of bath towels, hand towels and face cloths per resident for a total of 96 over a 24-hour period. This was considered the daily quota.

Staff reported that they were short of bath towels during the inspection and were often short of face and hand towels for resident care.

When the cart for the Clifton home area was delivered at 12:30 p.m. on April 24, 2023, there were only 60 bath towels, 30 hand towels and 18 face cloths. The Clifton home area had no face, hand, or bath towels in the linen storage room, on clean linen carts, tub, or shower areas or in many resident washrooms prior to lunch. At 2:29 p.m. on May 2, 2023, the Montrose home area linen cart included 17 hand, 60 face and 60 bath towels. On May 2, 2023, no supply of bath or hand towels was observed in the laundry room or storage/office of the laundry manager's office with the exception of approximately 60 face cloths. No back-up linen was available for emergencies. On May 3, 2023, the supervisor had obtained an additional 100 bath towels from another Conmed home. On May 3, 2023, at approximately 2 p.m. three linen carts were still missing the required quota of linens for delivery to three different home areas.

Sources: Direct observation, interview with PSWs, Housekeeping Supervisor, DES, review of linen policies and procedures and linen purchase invoices. [120]

WRITTEN NOTIFICATION: Laundry Services

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 95 (1) (c)

As part of the organized program of laundry services under clause 19 (1) (c) of the Act, the licensee failed to ensure that procedures were implemented to ensure that linen was maintained in a good state of repair.

Rationale and Summary

Numerous torn, threadbare, or frayed tablecloths were observed on tables in multiple dining rooms on each day of the inspection. Neither the dietary staff nor the laundry staff removed these tablecloths from circulation. The administrator did not order any new tablecloths in 2023 and identified that they had not received any requests to order new tablecloths from the laundry department staff. Records confirmed that tablecloths were not identified by the Housekeeping Supervisor for purchase.

Two identified resident rooms had privacy curtains that were ripped (mesh area). A privacy curtain in the Clifton shower room was too long and was pooling on the floor creating a possible trip hazard. The Housekeeping Supervisor identified that they did not have any spares.

The licensee's laundry procedure titled "Disposal of Worn Linens" did not include tablecloths in the list of the various linens that staff were to inspect during the laundering process and that it was the responsibility of both nursing and laundry department staff to remove torn linens from circulation. The purpose of the policy was identified to ensure that worn or torn linen be discarded. Further, the policy directed the Environmental Services Supervisor (ESS) to count discarded linen and complete the 'Linen Discard Form' and provide it to the Administrator weekly of the amount of discarded linen and arrangements made to replace these linens. The homes Environmental Services Director was not involved in the laundry program.

Sources: Interviews with the administrator, Housekeeping Supervisor, review of laundry policies and procedures, and direct observation. [120]

WRITTEN NOTIFICATION: Maintenance Services

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (a)

The licensee failed to ensure that procedures were implemented to ensure that electrical equipment was kept in good repair and maintained at a level that met manufacturer specifications, specifically ceiling lifts, and disinfection/washing units.

Rationale and Summary

The licensee owned over 20 resident lift tracks and motors in the home. The manufacturer requires that 17 different components and a lift test be conducted annually. A lift maintenance policy required the licensee to check certain lift motor components quarterly and to arrange an annual load test of all ceiling lifts by a representative of the manufacturer and to review the preventive maintenance contract. Health care staff were tasked at checking certain minor operational components, but other preventive checks were not completed by a qualified person. The Director of Environmental Services (DES) stated

that an external company conducted a load test of the ceiling lifts in 2022 but could not provide a contract or any service reports for the work. Stickers were observed on the ceiling tracks in resident rooms identifying that they were last load tested in January 2021. No documentation was provided as to who and when the motors were inspected by a qualified person for proper function.

Two flusher/disinfector machines were observed in the home, one in the Elgin soiled utility room and one in the Chippewa soiled utility room. The machine in the Elgin home area was not operational at any point during the four-day inspection. Personal support workers who worked the night shift and who were required to use the machines attested to using it nightly when cleaning bed pans and wash basins during the inspection period and did not report or document the disrepair to maintenance staff. Once the maintenance person was notified by the inspector of the malfunction, a qualified technician inspected them and found that neither were in good working order. The manufacturer recommends that 10 specific components and water temperature validation be completed every 7,500 cycles for optimum performance. A record of this system check was not available for review. Preventive maintenance policies did not include any guidance with respect to ensuring all equipment be maintained in accordance with manufacturer's specifications such as flushers/disinfectors.

Sources: Direct observation, review of maintenance policies and procedures, review of cleaning & disinfection tasks, interview with Personal Support Workers, Assistant Director of Care, Director of Care and DES. [120]

WRITTEN NOTIFICATION: Maintenance Services

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (h)

The licensee failed to ensure that procedures were implemented to ensure that immediate action was taken to reduce the water temperature in the event that it exceeded 49 degrees Celsius.

Rationale and Summary

Hot water temperatures at the mixing valve gauge (at the point where water was released to resident home areas) were documented by maintenance staff to be between 50°C and 51.6°C from Feb. 2 to April 25, 2023. On March 27, 2023, maintenance staff recorded 51°C in an identified resident room and registered staff recorded a temperature of 50.2°C on April 27, 2023, and 51°C on April 28, 2023, in a different resident room. This was following the inspector's concerns to maintenance staff that their hot water temperatures were being maintained over the maximum temperature of 49°C on April 24, 2023. Although maintenance staff attempted to adjust the source water temperature, it did not appear to change the temperatures in all areas of the home.

A policy regarding the taking of hot water temperatures required staff to take follow-up action when water temperatures were recorded over 49°C. This included taking a temperature at another sink (to determine if consistent) and notifying the supervisor of building maintenance. The licensee's water temperature log included an area on the form for notes for any action plans to be documented when water temperatures exceeded requirements. This area was blank for the month of April 2023.

Staff not implementing their hot water response and reporting procedures placed residents at moderate risk of scalding.

Sources: Interviews with registered staff, PSWs, maintenance staff and Administrator, review of water temperature procedures, water temperature logs, and independent water measurements. [120]

COMPLIANCE ORDER CO #001 Housekeeping

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1. The IPAC lead shall review and amend any procedure that deals with the handling of soiled devices (bed pans, wash basins and urinals) and determine what changes are necessary to ensure that the devices are cleaned and disinfected in accordance with best practices.
2. The IPAC lead shall provide face to face orientation based on the amended procedures to every PSW who handles soiled devices in the proper methods of cleaning and disinfecting them. A record of this orientation shall be kept and available for review during any subsequent inspections.
3. Develop an audit tool/checklist that is completed by the IPAC lead on a regular and frequent basis that includes but is not limited to reviewing how staff are complying with the procedures for cleaning and disinfecting tubs, showers, shower chairs, bed pans, wash basins and other equipment and devices used by or between residents. The audit shall include the date of the audit and any follow up action. The audit shall be made available for review during subsequent inspections.

Grounds
As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee failed to ensure that procedures were implemented for cleaning and disinfection of resident care equipment

such tubs and personal care devices in using a low-level disinfectant in accordance with evidence-based practices.

Rationale and Summary

Current evidence-based practices for cleaning and disinfecting non-critical personal care devices such as bed pans and wash basins and equipment such as tubs are identified in the document “Best Practices for Environmental Cleaning for Infection Prevention and Control”, April 2018 pp. 140-145. The document identifies the need to clean and disinfect the equipment and devices after each use.

A policy and procedure on cleaning tubs and showers required staff to check the shower/tub disinfecting solution daily to confirm an adequate supply for the next 24 hours and that tubs be cleaned and disinfected after each use.

A policy and procedure titled “Personal Care Equipment: Cleaning & Disinfecting” included the requirement for staff to apply a disinfectant wipe or a cloth saturated in disinfectant to visibly clean washbasins after use. If not visibly clean, the staff were directed to rinse the device and take it to the soiled utility room for cleaning and disinfecting before returning it to the resident’s room. Conmed’s previous policy titled "Cleaning and Disinfection" also required staff to clean devices with soap and water, followed by disinfecting with disinfectant wipes.

The same policy included the requirement for staff to take full bed pans to the soiled utility room and flush the contents down the hopper and to use a flusher/disinfector if one was available. If not, the staff were to clean and disinfect the bed pan but was unclear about how to do this as it did not include the use of a sink. Best practices do not include or advocate that body fluids be carried into soiled utility rooms, but that the contents be flushed in the residents own washroom toilet.

The licensee did not have soiled utility rooms set up for staff to conduct any manual cleaning. No utility sink was available in any soiled utility room in the home and only two home areas had a flusher/disinfector machine, and neither were in good repair at the time of the inspection (over 8 days). The rooms did not include cleaning or disinfection supplies and were full of soiled utility carts that were blocking access to a fixture known as a hopper, which is used to dispose body fluids and rinsing bed pans and not an appropriate fixture in which to wash any item.

Interviews with 3 staff members, all who were not regular employees of the home, but from an agency, revealed that basins were typically rinsed and left to air dry, or sometimes hand soap was used with paper towel, rinsed, or wiped out with paper towel, and left to dry. Two PSWs stated that they had not been provided with any orientation to any disinfection policies in the home and had never used the

soiled utility room for any purpose other than to store soiled linen carts.

The Director of Care (DOC) and Assistant Director of Care (ADOC) reported that night shift staff were tasked at taking the devices once per week to the soiled utility room where the flusher/disinfector machine was to be used.

A heavily soiled and encrusted bed pan was identified in a resident's washroom on April 24, 2023, and again on each day of the inspection. According to the night shift task routine, a night shift PSW checked off that the item had been cleaned using the flusher/disinfector that same week.

None of the 20 different resident rooms that were observed during the inspection had any disinfectant wipes readily available for staff use. A night shift routine that was provided for an identified home area, included written directions for personal support workers to stock resident rooms with disinfectant wipes and other supplies.

A tub on an identified home area did not have any disinfectant in the jug which was stored inside the tub over an 8-day period. The tub was regularly used for resident baths throughout the week based on observation and discussion with various PSWs.

The ADOC or DOC did not monitor, evaluate, or determine whether staff were complying with any policy. No audits or reviews were conducted to ensure that care staff were compliant or understood what was required. Neither policy was amended to reflect the fact that flusher/disinfector machines were available and that the home did not have any sinks in which to manually clean items if needed. Inadequate cleaning and disinfection of devices and equipment are essential for reducing the risk of spreading enteric pathogens from one body part to another or from person to person.

Sources: Interviews with personal support workers, ADOC, DOC, review of infection prevention and control policies and procedures, cleaning schedules. [120]

This order must be complied with by September 1, 2023

COMPLIANCE ORDER CO #002 Maintenance Services

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 96 (2) (g)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Assign a designated person to immediately audit the hot water temperature logs that are required to be completed by staff in the home. The auditing shall continue daily until July 31, 2023, and routinely thereafter. The audits shall include at a minimum;

a) that an accurate thermometer is used to take hot water temperatures, and
b) that hot water temperatures are taken in random resident spaces, including tub and shower rooms, common washrooms, and dining rooms, and
c) that hot water temperatures are measured and monitored on each shift, and
d) any immediate responses taken when hot water exceeds 49 degrees Celsius is documented.

The results of the audit shall be available for review on any subsequent inspection.

Grounds

The licensee failed to ensure that procedures were implemented to ensure that the temperature of the water serving all bathtubs, showers, and hand basins used by residents did not exceed 49 degrees Celsius.

Rationale and Summary

The inspector measured the hot water temperature in several random areas using a calibrated digital probe thermometer. On April 24, 2023, the temperature was 53.5 degrees Celsius (°C) at the hand sink in the common washroom near the nurse's station, 51.7 °C at the hand sink in the common washroom near the balcony, and 52.5°C at the dining room sink in the Clifton home area. The exceedances were reported to the registered nurse in the Clifton home area, who was unaware of the issue and who subsequently reported the issue to maintenance staff. The maintenance person verified the temperatures. The temperature at the source was over 52°C and adjusted, and a few hours later the temperature was 43°C at the dining room sink in the Montrose home area. However, staff complained that there was insufficient hot water (below 40°C) at the shower in the Montrose home area.

On March 27, 2023, maintenance staff recorded 51°C in an identified resident room and registered staff recorded a temperature of 50.2°C on April 27, 2023, and 51°C on April 28, 2023, in a different resident room. The inspector did not verify the accuracy of the digital thermometers that registered staff used to take water temperatures and no instructions were included in the licensee's policy for staff to determine their accuracy.

According to a policy regarding water temperature monitoring, staff were to monitor the water temperatures in tub and shower rooms and other sinks once per shift in random locations where residents had access to hot water and to record the temperatures on a specific water temperature log.

Staff were to follow certain procedures to ensure the hot water remained below 49°C. The water temperature logs reviewed for Clifton and Elgin home areas did not include any temperatures taken in tub or shower areas, or common area sinks (which tended to be higher than other sink temperatures) and also included medication room sinks (to which residents did not have access).

Staff not implementing their procedures regarding recording and monitoring where required placed residents at high risk of scalding.

Sources: Interviews with registered staff, PSWs, maintenance staff and Administrator, review of water temperature procedures, water temperature logs, and independent water measurements. [120]

This order must be complied with by July 31, 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;
(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
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) 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:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) 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
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: 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.