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
119 King Street West, 11th Floor
Hamilton, ON, L8P 4Y7
Telephone: (800) 461-7137

Original Public Report

Report Issue Date: December 18, 2023
Inspection Number: 2023-1432-0008
Inspection Type: Complaint Follow up
Licensee: 955464 Ontario Limited
Long Term Care Home and City: Millennium Trail Manor, Niagara Falls

Lead Inspector	**Inspector Digital Signature**
Bernadette Susnik (120)	Bernadette Susnik Digitally signed by Bernadette Susnik Date: 2024.01.15 09:59:35 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 20, 21, 23, 28, 2023
The inspection occurred offsite on the following date(s): November 27, 29, 30, 2023

The following intake(s) were inspected:

- Intake: #00089606 was a follow-up inspection related to cleaning of resident care equipment.
- Intake: #00089607 was a follow-up inspection related to maintenance services (water temperature).
- Intake: #00089608 was a follow-up inspection related to cleaning of the home.

- Intake: #00089609 was a follow-up inspection related to the condition of the home, equipment, and furnishings.
- Intake: #00089610 was a follow-up inspection related to door security.
- Intake: #00102028 was a complaint regarding the pest control program.

Previously Issued Compliance Order(s)

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

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

Order #002 from Inspection #2023-1432-0005 related to O. Reg. 246/22, s. 96 (2) (g) (Maintenance services – water temperatures) inspected by Bernadette Susnik (120)

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

Order #001 from Inspection #2023-1432-0005 related to O. Reg. 246/22, s. 93 (2) (b) (Cleaning of resident care equipment) inspected by Bernadette Susnik (120)

Order #002 from Inspection #2022-1432-0003 related to FLTCA, 2021, s. 19 (2) (c) (Condition of the home, equipment, and furnishings) inspected by Bernadette Susnik (120)

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

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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: Housekeeping

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of licence
Licensee must comply
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

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 Order set out the following:

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 this follow-up inspection, the order was not complied with, specifically a) and c).

Rationale and summary

During the follow-up inspection, each of the three serveries were noted to have visible soiling and heavy amounts of hard water scale on the frame of the dishwasher as well as on the floor under them. Drawers and cabinet door surfaces, edges and interior areas were not all free of debris and stains. Walls, baseboards, and ceilings (especially on the second floor) were visibly soiled with food/liquid matter in the second floor servery. Sinks were stained brown and the area around the taps dirty. The food service carts, and soiled dish carts (parked in dining rooms) were all heavily soiled on their surfaces, some with black stains resembling mould.

The Dietary Manager identified that deep cleaning took place in the kitchen on November 3, 2023, but no records were provided as to what deep cleaning tasks occurred in each of the three serveries. Daily and weekly cleaning schedules identified which appliances and surfaces were to be cleaned, however, many were only allocated to be cleaned once or twice per week. The flooring was to be cleaned daily, along with the carts. Staff signed off that all tasks had been completed, but this was not obvious over the 7-days of the inspection.

The housekeeping supervisor (with an external service provider) identified that the

deep cleaning of the servery and kitchen floors occurred only once per month and that they had not been requested to deep clean anything else.

Dietary staff stated that the number of dietary staff or time allocated for cleaning the serveries was insufficient, as they could not complete other duties related to meal time preparation.
The licensee's deep cleaning and routine cleaning frequencies for the serveries had not been either implemented, amended, or altered since the previous inspection.

Sources: Direct observation, review of housekeeping procedures and cleaning schedules, interview with Housekeeping Supervisor, Dietary Manager and Administrator. [120]

This Written Notification is being referred to the Director for further action by the Director.

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 $2200.00, 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.

Compliance History:
Prior non-compliance was issued under O. Regulation 246/22, s. 93(2)(a), resulting in NC #005 (WN and AMP) on July 24, 2023, from inspection #2023-1432-0005, CO #004 on January 3, 2023, from inspection #2022-1432-0003.

This is the second AMP that has been issued to the licensee for failing 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: Housekeeping

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of licence
Licensee must comply
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

The licensee has failed to comply with the conditions of Compliance Order (CO)

#001 from inspection #2023-1432-0005 related to housekeeping services under s. 93 (2) (b) (ii) of O. Regulation 246/22, served on July 23, 2023, with a compliance due date of September 1, 2023.

The Order set out the following;

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.

During this follow-up inspection, #3 of the Order was not complied with.

Rationale and Summary

The audits that were completed since the Order was served in July 2023, did not include any that were completed by an IPAC lead. The audits were completed by personal support workers (PSW) in each home area. The role of the PSW was not to audit their colleague's adherence to established policies and procedures. The

results of the audits failed to include any issues related to how other PSWs were cleaning and disinfecting personal care devices such as bed pans and wash basins.

During the inspection, many of the personal care devices were not being disinfected after each use. This was determined by staff interviews and observing wash basins upside down over the resident's hand sink or standing water in wash basins (which occurred when staff rinsed the basin and did not proceed with using a paper towel to dry it and then to use a disposable disinfectant wipe afterwards). Some resident washrooms had no disinfectant wipes, and some resident washrooms had disinfectant wipe containers that were still sealed shut after four days.

During the inspection, numerous resident washrooms in each of the five resident home areas were observed to have urine hats and bed pans stored inappropriately on grab bars and towel bars, or on commode chairs or on the floor within the washroom. Wash basins were observed upside down inside of resident's hand wash sinks, or on the floor. Nail clippers were stored on top of storage carts in three different tub rooms instead of in the resident's designated trays.

Sources: Observations, review of completed audits, staff training attendance records, training materials and IPAC policies and procedures, interview with personal support workers, the Director of Care and IPAC lead. [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.

Compliance History:

Prior non-compliance was issued under O. Regulation 246/22, s. 93(2)(b)(ii), resulting in CO #001 on July 24, 2023, from inspection #2023-1432-0005.

This is the first AMP that has been issued to the licensee for failing 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: Maintenance services

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 104 (4)
Conditions of licence
Licensee must comply
s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

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.

The Order set out the following:

The licensee must address the following deficiencies;

a) 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.

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

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

d) 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.

e) 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 follow-up inspection, the Order was not complied with, specifically c), d) and e).

Rationale and Summary

When windows were tested during the inspection, they were difficult to slide open or closed. Several slid down on their own account when left in the up position. Many could not be locked. An identified resident complained to the inspector when

touring their room that they were upset that they could not open or close their windows without assistance from a personal support worker. The maintenance supervisor completed an audit of the function of each window in June 2023 and identified 16 that required certain components to be replaced. The windows had not been repaired as required by March 31, 2023, or by the end of the inspection.

An audit was not conducted of the home using an audit form or checklist to determine what other deficiencies required attention that were not identified in the grounds specified in inspection report #2022-1432-0003 served on January 4, 2023. During the follow-up inspection beginning on November 20, 2023, numerous maintenance related issues were identified in resident rooms and washrooms, serveries, and common areas. An audit was completed in one day by the maintenance supervisor identifying that no issues were identified with any surfaces or fixtures in any resident bedroom or washroom. No audits were developed or completed for other areas of the home.

A plan was not provided before or during the follow-up inspection as to how the licensee intended to ensure that adequate maintenance hours or personnel would be available to maintain the home, furnishings, and equipment in a safe condition and in a good state of repair. Based on the given maintenance staffing compliment observed during the inspection, it appeared that it would be difficult to complete all of the required tasks in a timely manner.

Sources: Observations, interview with the Administrator, maintenance staff, review of resident room audits and window audit checklist. [120]

This Written Notification is being referred to the Director for further action by the Director.

An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #003

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 $2200.00, 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.

Compliance History:

Prior non-compliance was issued under FLTCA, 2021, s. 19(2)(c), resulting in NC #002 (WN and AMP #2) on July 24, 2023, from inspection #2023-1432-0005, CO #002 on January 3, 2023, from inspection #2022-1432-0003.

This is the second AMP that has been issued to the licensee for failing 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: Specific duties re cleanliness and repair

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (1) (b)
Maintenance services
s. 96 (1) As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance.

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

Rationale and Summary

The Extendicare preventive policies and procedures that the licensee acquired in September 2022, included sample checklists for annual auditing of resident rooms and common areas, but not for tub/shower rooms, staff areas (lunchrooms, locker rooms, common washrooms), serveries and the main kitchen. The licensee's previous preventive maintenance policies and procedures did not include common area or staff area checklists. The licensee failed to complete comprehensive audits to determine the status or the condition of the furnishings and their home in general. During a tour of the home, the following conditions were observed:

- Bedroom night tables in numerous resident rooms in each resident home area (RHA) were not in good condition. The top edge at the front of the tables had laminate that had eroded away along the seam exposing sharp edges and particle board underneath. The maintenance supervisor was aware of their condition. Resident washroom cabinet doors, along with numerous

cabinet tops and the washroom vanity cabinet door in the Stamford bathing area washroom also were damaged with exposed particle board. Many of the cabinet doors hit the top of the drawer below when opened. A footboard was observed to be in bad condition in an identified resident room.

- Carpet tiles were observed to be lifting in most of the lounges in each RHA. The licensee was unaware of their condition and did not initiate a plan to replace them until raised during the inspection.
- The ceiling drywall located in the 2nd floor servery was not in good condition. The ceiling had been patched from a previous water leak around a light fixture near the dishwasher. The drywall had not been painted and the material was crumbling, and the surface was not smooth. Neither the administrator or the maintenance supervisor could provide a date when the patch work was completed and why it was not painted soon thereafter.
- Chrome product holders noted in some of the tub/shower areas to be heavily rusted.
- Five wall ceramic tiles were cracked and pieces missing from the corner of two walls in the shower area of the Chippewa home area. The wall was in the same condition for over six months.
- Cracked or missing light covers observed in at least five resident washrooms. The issue was noted by the maintenance supervisor as an ongoing challenge due to the low ceilings, size and long length of the light fixture and staff use of mechanical floor lifts that damage the light covers. The maintenance supervisor had begun replacing the lights fixtures with smaller round fixtures in the past, but this was not observed as an ongoing plan during the inspection.
- Flooring in the walk-in fridge was rusted and unsealed.

- The glass refrigerator located in the first floor servery had a ripped gasket.
- The ceilings in the Clifton tub and shower were patched with drywall mud on an unknown date and remained unfinished until the last day of inspection on November 28, 2023.

Resident bedrooms and bathrooms were audited by the maintenance person five times in 2023, the latest being in September 2023, using their previous checklist. All 160 spaces were completed in one day, with no findings. The checklist used by the maintenance supervisor did not include the surfaces and furnishings that were included in the Extendicare resident bedroom and washroom checklist. The vast majority of the deficiencies in the home were normally brought to the attention of maintenance staff through a software application by various staff members. Many of the staff members who were interviewed in the home did not use the system, and occasionally would inform the charge nurse on their RHA, who in turn would submit a work request. The maintenance program was highly remedial in nature.

Failure to ensure that the maintenance program includes a comprehensive routine preventative component has led to many extensive deficiencies that have progressed beyond simple repairs.

Sources: Observations, review of existing maintenance policies and procedures and schedules, interviews with the administrator and the maintenance supervisor. [120]

WRITTEN NOTIFICATION: Infection Prevention and Control

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 has failed to implement any Standard issued by the Director with respect to infection prevention and control, specifically, under sections 5.3, 9.1 (e), i and 10.5 of the Infection Prevention and Control (IPAC) Standard, revised September 2023.

Rationale and Summary

Under section 5.3 of the IPAC Standard, the licensee was to ensure that the policies and procedures for the IPAC program included policies and procedures for the implementation of Routine Practices and Additional Precautions, specifically the use of environmental controls which is required under section 9.1.(e), i.

Under section 9.1 (e) i, of the IPAC Standard, the licensee was to ensure that Routine Practices were followed with respect to the location or placement or storage of residents' personal care equipment (bed pans, wash basins, urinals). The licensee did not develop or include in their existing policies where exactly staff were to store personal care equipment considering that resident's washrooms were not equipped with storage cabinetry, shelving or another storage solution to accommodate the size of the personal care equipment being used.

The licensee's policy IC-02-01-12 (Personal Care Equipment: Cleaning and Disinfecting) specified that staff were to store nail clippers and personal care equipment in a clean and sanitary manner or in a manner to prevent contamination. An addendum to this policy, included that staff were to store bedpans, urinals and washbasins in the resident's washroom, the washroom cupboard or bedside table. The direction was not clear how staff were to store items in a manner to prevent contamination.

During the inspection, numerous resident washrooms in each of the five resident home areas were observed to have urine hats and bed pans stored on grab bars and towel bars, or on commode chairs or on the floor within the washroom. Wash basins were observed upside down inside of resident's hand wash sinks, or on the

floor. Excessive hygiene supplies, such as peri care products and toilet paper rolls (4 to 6) were stored on toilet tank lids or in the limited storage cabinets. Excessive number of briefs were observed on resident's vanity tops right behind the sink taps and stuffed into drawers designed for smaller items. In tub and shower rooms, boxes of tissue were stored on grab bars and glove boxes were stored on toilet tank lids and towel or grab bars. Nail clippers were stored on top of storage carts in three different tub rooms instead of in the resident's designated trays.

Although the resident washrooms had a cabinet and two drawers for their personal hygiene supplies, they could not accommodate the size and shape of the personal care equipment such as wash basins and bed pans. Although wash basins were mostly being stored on top of the cabinets, no alternative was in place for bed pans. The urine hats were required to be disposed of after each use. The cabinets were also insufficiently equipped with shelving to accommodate necessary supplies. Most of the cabinets, which could easily accommodate two or three shelves, were only equipped with one, which was the base of the cabinet or an additional shelf above that.

Some resident washrooms included household items and furnishings, which not only impeded access for staff to be able to use any floor lift equipment, but the items were subject to higher-than-normal levels of contamination.

Under section 10.3 of the IPAC Standard, eye wash stations must not be attached to hand washing sinks. Numerous hand washing sinks throughout the home (kitchen, nurses' stations, soiled utility rooms, housekeeping storage rooms) had eye wash hardware attached directly onto the spigot of the hand wash sink. Those that were located in the soiled utility and housekeeping rooms were especially difficult to use as the flow of water was reduced and located toward the back of the sink. When tested, the hands would hit the back of the sink. No action was taken to consult with their local Ministry of Labour, Immigration, Training and Skills Development

inspector or the Public Services Health and Safety Association to determine what alternatives were available.

Failure to ensure that the environment is arranged or designed to allow for proper storage, and that the environment is maintained to limit the number of surfaces that can become contaminated and allow for proper cleaning and disinfection may impede the process of controlling the spread of infectious agents.

Sources: Observations, review of the licensees IPAC related policies and procedures, interview with the IPAC lead and Director of Care. [120]

COMPLIANCE ORDER CO #001 Specific duties re cleanliness and repair

NC #006 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 19 (2) (a)
Accommodation services
Specific duties re cleanliness and repair
s. 19 (2) Every licensee of a long-term care home shall ensure that (a) the home, furnishings and equipment are kept clean and sanitary;

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with FLTCA, 2021, s. 19 (2) (a) [FLTCA, 2021, s. 155 (1) (b)]:

Please submit the written plan for achieving compliance for inspection #2023-1432-0008 to Bernadette Susnik (120), LTC Homes Inspector, MLTC, by email to hamiltondistrict.mltc@ontario.ca by January 15, 2024.

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

1. The plan shall include immediate actions and long-term sustainable actions to address the findings in the grounds identified below.
2. The plan shall include the dates that the identified areas, furnishings, and equipment identified in the grounds below were thoroughly cleaned, by whom, how and the additional hours that were added to complete the cleaning.
3. The plan shall be developed by an interdisciplinary team that includes the Administrator, Activation Manager, Director of Care or Associate Director of Care, Dietary Manager, Sunshine housekeeping manager, IPAC lead, CQI lead and maintenance supervisor.
4. The plan shall include what if any training and orientation is required for staff to complete the tasks that they are accountable for.
5. The plan shall include what cleaning policies and procedures, audits and schedules require development or amendments, and timelines for implementation, which includes staff orientation.

Grounds

The licensee has failed to keep the home, equipment, and furnishings clean and sanitary.

Rationale and Summary

On November 28, 2023, seven wheelchairs were observed to be heavily soiled with food debris, dust, and other matter, which included the frames, seat cushions, under the seat cushions, sides, and wheels. Night shift staff who were responsible for cleaning the wheelchairs documented that two were deep cleaned on November 27th, 2023. Based on the extent of the accumulation, staff on night shift did not clean the chairs they identified in records, and staff on day or evening shifts did not clean the wheelchairs as spills occurred, especially during or just after meal service.

Cleaning and disinfecting resident care equipment procedures RC 07-01-01 and IC - 02-01-011 did not include any information about who was responsible for cleaning wheelchairs, where to clean them or how often. According to the PSW night cleaning schedule, wheelchairs were required to be deep cleaned once per week. No location within the home was set up to accommodate wheelchair cleaning, including the soiled utility rooms which did not have a multi-use deep sink for washing devices, equipment or other equipment and supplies.

On November 20, 2023, and November 28, 2023, the dishwashers on each floor were heavily encrusted along their frames with accumulated mineral deposits or water scale. The dish wash trays were heavily encrusted with scale in the main kitchen and in each servery. A mixer, observed sitting on a dish wash tray, had a thick layer of scale on its underside. The flooring in and around each dishwasher was coated in scale. Many of the sink faucets throughout the building had copper precipitate on them or hard water scale. A de-scaling product was available in the home and Sunshine housekeeping procedures included direction for surfaces (in non-dietary areas) to be removed. No deliming or descaling procedures were developed for dietary services to address this issue.

The activity rooms on each floor (across from the elevators) were dirty. Heavy accumulation of debris was noted in and around the stove on the second floor, and moderate amount of staining around both refrigerators. The sink was brown with stains. The interior of the oven had a heavy build-up of stuck on stains and spills. The third-floor activity room was similar but had less accumulated floor matter around the stove. An activation staff member stated that they did not clean the kitchen area of the room, that it was up to the housekeepers. Sunshine housekeeping procedures or the licensee's procedures did not include a cleaning routine and tasks for these rooms.

The care carts that were parked next to the tub in four out of the five tub rooms were visibly dirty. A build-up of dust, debris and other stains were obvious from Nov.

20th to Nov. 28th, 2023. The PSWs night cleaning schedule did not include this equipment and no procedures under the licensee's nursing care manual allocated this task to PSW's tasks. Sunshine housekeeping procedures did not include cleaning carts in tub or shower rooms.

The dirty dish carts and the snack carts in each of the five home areas were visibly dirty. Food debris and mould stains were observed on surfaces and in corners and in the textured handles. No deep cleaning schedule had been developed for them. The Dietary Manager identified that deep cleaning of the dietary spaces and equipment was only arranged when they could assign some extra hours to an available dietary staff person. The last deep clean of the main kitchen and equipment occurred on November 3, 2023. Dietary staff reported just wiping the carts down daily. The cart washroom that was approved for the use of all carts, was converted to a storage room approximately 12 years prior. Some staff reported having used a power hose outside, but this was not conducive in the winter months.

A heavy amount of debris was noted on the floor under and behind shelving in the main walk-in cooler in the kitchen. Wire rack shelving was dirty. The fan covers and ceiling above them were dusty.

The kitchen ceiling and some light covers were dusty and spotted with food stains.

The interior of most of the exhaust vents in the soiled utility rooms, tub rooms, shower rooms, washrooms within the tub and shower rooms and chute rooms were thick with dust. Sunshine housekeeping policies included dusting of the vents, but not the interior, which requires some disassembly. The licensee's housekeeping procedure Appendix 10 included a minimum of an annual deep clean.

A black powdery substance resembling soot (a by-product of incomplete combustion of fuels) was observed on many privacy curtains and on the ceiling or resident rooms and some common spaces. The air supply vents had pushed the

soot-laden air onto surfaces that were in the path of the air flow. This issue was not addressed in any of the licensee's procedures.

Sources: Observations, interview with Sunshine housekeeping supervisor, dietary staff, maintenance supervisor, Director of Care, Dietary Manager and Administrator. [120]

This order must be complied with by: February 15, 2024

NOTICE OF RE-INSPECTION FEE

Pursuant to section 348 of O. Reg. 246/22 of the Fixing Long-Term Care Act, 2021, the licensee is subject to a re-inspection fee of $500.00 to be paid within 30 days from the date of the invoice.

A re-inspection fee applies since this is, at minimum, the second follow-up inspection to determine compliance with the following Compliance Order(s) under s. 155 of the FLTCA, 2021, and/or s. 153 of the LTCHA, 2007.

Follow-up to existing compliance orders.

Licensees must not pay a Re-Inspection Fee 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 Re-Inspection Fee.

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

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.