Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 5, 2019	2019_539120_0001	006097-18, 013573-18, 024759-18	Complaint

Licensee/Titulaire de permis

Chartwell Master Care LP
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

Long-Term Care Home/Foyer de soins de longue durée

Chartwell Niagara Long Term Care Residence
120 Wellington Street P.O. Box 985 NIAGARA-ON-THE-LAKE ON L0S 1J0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 3, 4 and 9, 2019

The following three complaints were reviewed during this inspection:

#006097-18 related to an injury.
#013573-18 related to odours, access to an electrical panel, housekeeping, infection prevention and control, condition of furnishings and elevator maintenance.
#024759-18 related to linen supplies and the comfort of residents during extreme heat.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Environmental Services Supervisor (ESS), Registered Nurses (RN), Registered Practical Nurses (RPN), personal support workers (PSW) and laundry aides.

During the course of the inspection, the inspector toured the first and second floors, including resident rooms and utility rooms, observed resident bed systems, outbreak supplies, housekeeping and linen supplies, reviewed housekeeping, laundry and maintenance policies and procedures, infection prevention and control policies, outbreak documentation, staff and resident immunization rates, staff work schedules, resident heat assessments, hot weather related management policies, air temperature logs, hot water temperature logs, maintenance request logs, maintenance service reports and bed system entrapment and condition audits.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Critical Incident Response
Infection Prevention and Control
Personal Support Services
Safe and Secure Home
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

7 WN(s)
4 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the equipment was maintained in a safe condition.

The licensee's bed systems were observed in random resident rooms during the inspection. Several styles or bed models were available. Approximately six identified beds were observed with hardware (metal bracket with black roller attached to the end) on the sides of each bed. The rollers were identified by the Environmental Services Supervisor (ESS) to have been left on the beds after the licensee's former maintenance person took the half length bed rails off in mid 2018. The rollers were designed to guide the bed rails and to keep them from rubbing against the deck of the bed. Once removed, the rollers (two on each side) protruded from the deck of the bed by approximately one to two inches. The protrusions were a cause for concern for potential skin tears.

Two different bed systems in two identified resident rooms were observed with metal mounting hardware on the sides of the bed. The metal protruded out from the deck of the bed slightly and had moderately sharp edging. According to the ESS, the hardware was not difficult to remove and should have been removed with the bed rail.

Bed systems in but not limited to four identified resident rooms were observed with mattresses sitting on top of the mattress keepers at the head end of the beds. These beds did not have any bed rails attached. Manipulation of the mattresses to try and make them fit between the keepers was difficult. It appeared that the bed frame was not compatible with the mattresses that were provided. According to the manufacturer's instructions for the bed systems observed, mattresses that are not compatible with the deck platform of the bed may slide about and/or cause operational issues. The mattress keepers were either missing or broken in one identified resident room thereby also allowing the bed mattress to slide about on the deck platform, which was smooth.

The ESS provided documentation that only those beds with attached bed rails were checked by designated staff for maintenance and safety related concerns in December 2018.

The licensee did not ensure that equipment was maintained in a safe condition. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that equipment was maintained in a safe condition, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
1. Customary routines. O. Reg. 79/10, s. 26 (3).
2. Cognition ability. O. Reg. 79/10, s. 26 (3).
3. Communication abilities, including hearing and language. O. Reg. 79/10, s. 26 (3).
4. Vision. O. Reg. 79/10, s. 26 (3).
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).
6. Psychological well-being. O. Reg. 79/10, s. 26 (3).
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming. O. Reg. 79/10, s. 26 (3).
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).
9. Disease diagnosis. O. Reg. 79/10, s. 26 (3).
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).
11. Seasonal risk relating to hot weather. O. Reg. 79/10, s. 26 (3).
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).
13. Nutritional status, including height, weight and any risks relating to nutrition care. O. Reg. 79/10, s. 26 (3).
14. Hydration status and any risks relating to hydration. O. Reg. 79/10, s. 26 (3).
15. Skin condition, including altered skin integrity and foot conditions. O. Reg. 79/10, s. 26 (3).
16. Activity patterns and pursuits. O. Reg. 79/10, s. 26 (3).
17. Drugs and treatments. O. Reg. 79/10, s. 26 (3).
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).
19. Safety risks. O. Reg. 79/10, s. 26 (3).
20. Nausea and vomiting. O. Reg. 79/10, s. 26 (3).
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).
22. Cultural, spiritual and religious preferences and age-related needs and preferences. O. Reg. 79/10, s. 26 (3).
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. A plan of care must be based on, at a minimum, an interdisciplinary assessment of seasonal risk relating to hot weather with respect to the resident.

A complaint (#24759-18) was received in September 2018, that several identified residents (#002, #003, #004) were complaining about the uncomfortable heat conditions in their room during a heat alert issued during the month of August 2018. The complainant stated that they did not believe that staff were doing enough to keep the resident's comfortable and to ensure that the residents did not begin to experience heat-related symptoms.

During the inspection, the identified three residents were selected to determine if their plan of care included an interdisciplinary assessment of seasonal risk relating specifically to hot weather. An interdisciplinary assessment includes input from various members of the management team such as dietary, recreation, nursing, restorative, accommodation services, pharmaceutical, and spiritual/religious.

1. Resident #003 was assessed in April 2018, at risk for heat stress due to several health conditions. Although not identified on the assessment, the resident's written plan of care dated July 2018, identified that they had an additional health condition and were at risk of dehydration and at nutritional risk, but no focus, goal or interventions were included to address their heat risk status.

In September 2018, a progress note was made by registered staff member that identified that the resident was complaining about the heat and not feeling well but refused to leave their room. Staff response included pushing fluids and encouragement to go to an air conditioned common area. The interventions that were suggested to the resident were obtained from the licensee's policy entitled "Heat Prevention - Hot Weather", dated December 2017.

Under the focus of "Nutritional Status", no interventions were included that related specifically to heat risk and did not direct care staff as to when to increase monitoring of intake, how often to monitor and whether the intake would be documented. Under the focus of "Dehydration Risk", no information was included related to whether intake should be increased during high heat episodes and by how much. It was not clear exactly what health care staff were to do when environmental conditions, such as humidity and temperature, became uncomfortable and could impact the resident's health negatively for

each identified condition.

2. Resident #002 was assessed in April 2018, as risk for heat stress due to multiple health conditions. Although not identified on the heat risk assessment, a nutritional/hydration risk assessment completed in June 2018, revealed additional health conditions which also placed the resident at risk nutritionally. According to the resident's plan of care revised and updated in September 2018, a focus, goal and interventions for the resident's status with respect to heat stress was included, however, the interventions were not specific and directed staff to educate the resident about the licensee's heat prevention policy, to drink extra fluid, not go outside for long periods of time and to watch for signs of heat stroke. The interventions were not specific to the resident's various health conditions.

Under the focus of "Nutritional Status", no interventions were included that related specifically to times when the resident's environment was uncomfortable (increased air temperatures and humidity) and did not direct care staff as to when to increase monitoring of intake, how often to monitor and whether the intake would be documented. Under the focus of "Dehydration Risk", the interventions included monitoring for signs of dehydration and to provide diet as ordered. No information was included as to whether the monitoring needed to increase or change in any way if environmental conditions changed or whether intake should be increased during high heat episodes and by how much. It was not clear exactly what health care staff were to do when environmental conditions, such as humidity and temperature, became uncomfortable and could impact the resident's health negatively for each identified condition. [s. 26. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a plan of care is based on, at a minimum, an interdisciplinary assessment of seasonal risk relating to hot weather with respect to the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that, as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, that policies and procedures for cleaning and disinfection were implemented for devices in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with prevailing practices.

According to the licensee's policies and procedures for cleaning and disinfecting equipment and devices entitled "Cleaning, Disinfection and Sterilization", (LTC-CA-WQ-205-02-01) dated January 2015, devices such as bath basins or bed pans were to be thoroughly cleaned followed by low level disinfection after each use. The policy included the use of water and detergents during a cleaning stage followed by the use of a chemical disinfectant (specific disinfectant not identified but a range of products listed). The direction was identified to be in accordance with prevailing practices developed by Public Health Ontario entitled "Best Practices for Environmental Cleaning for Infection Prevention and Control in All Health Care Settings", April 2018 and "Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment/Devices", 2014. Both best practices included the need to first clean the devices (also identified as non-critical items) followed by low level disinfection. Further direction in the licensee's policy required staff to take the devices to the dirty utility room. No specific information was available about where exactly the devices were to be cleaned (i.e. sink), how and which type of disinfectant would be used and how to apply it. The policy clearly identified that

disinfectant wipes should not be used on resident care equipment that could be soaked due to difficulty in attaining adequate disinfectant contact time with the wipes. There were no further directions about the use of disinfectant wipes, which are acceptable for use on non-critical items as long as staff follow the manufacturer's instructions.

According to PSWs #102 and #103, the above noted devices were wiped down once per week with a disposable disinfectant wipe during the night shift. One staff member reported that they used two disinfectant wipes and the other reported using only one. Neither staff reported that the devices were taken to a dirty utility room and soaked. The frequency was in accordance with the home's schedule which was reviewed and included a frequency "to clean" the devices once per week and did not include any specific procedures. During the day shift, PSWs #108, #109 and #110 stated that the waste water or waste materials were disposed of in the resident's hand sink or toilet and were either rinsed with hot water after use in the resident's hand sink or wiped down with a disposable disinfectant wipe. Both day and night shift staff reported that heavily soiled devices were thrown out. Staff #103 reported that if new devices were not available to replace heavily soiled devices that they were rinsed off in the hopper in the soiled utility room using a spray hose, which is not an approved prevailing practice to control the spread of contaminants. Other staff also reported not always having readily available replacement devices.

During a tour of the home conducted over the course of three days, the dirty utility rooms were observed to be ill equipped for reprocessing devices in accordance with the above noted best practices. Two of the rooms were equipped with a white porcelain or ceramic sink which served as hoppers (flush mechanism was not operational) to dispose of bodily waste, with no faucets and a hand held sprayer. One identified utility room had a small white ceramic hand sink and the other utility room had a stainless steel domestic-sized sink. Cleaning and/or cleaning and disinfectant solutions were not provided in either room, there were no drying racks (no counter space was available in the third floor utility room) and the ceramic hand sink was not appropriate for immersion cleaning.

The licensee failed to ensure that policies and procedures for cleaning and disinfection were developed and implemented for devices in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with prevailing practices. A designated reprocessing area (dirty utility rooms) was not properly designed and equipped to allow staff to clean and disinfect soiled devices if needed. Secondly, the policy did not provide clear instructions or procedures for staff to clean and disinfect soiled devices, whether through the use of disinfectant wipes or the use of other

types of disinfectants. [s. 87. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, that policies and procedures for cleaning and disinfection are developed and implemented for devices in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with prevailing practices., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed, no later than one business day after the occurrence of an incident that caused an injury to a resident that resulted in a significant change in the residents health condition and for which the resident was taken to a hospital.

The term "significant" change under s. 107(7) means a major change in the resident's health condition that will not resolve itself without further intervention, impacts on more than one aspect of the resident's health condition, and requires an assessment by the interdisciplinary team or a revision to the resident's plan of care. According to RPN #105 and the resident's clinical records, confirmation was made that all three factors applied in this case.

Resident #001 sustained an injury in March 2018, during a staff assisted transfer from one surface to another. According to documentation provided by the Administrator and interviews with registered staff #102 and #103 and personal support workers #106 and #107 during the inspection, the resident's assistive device was placed very close to the side of the bed so that the resident could grab onto a component of the bed system to assist themselves to stand up. It was assumed that the resident injured themselves on a component of the bed system during this process. The resident's injury could not be managed in the home and the resident was subsequently sent to the hospital for treatment. According to RPN #105, the resident's health condition was impacted by the injury and an interdisciplinary team had to revise the resident's plan of care to reflect the changes. The residents activities of daily living and care levels changed after the incident.

The Director of Care who was employed at the home in March 2018, was no longer employed at the home at the time of inspection to determine why a critical incident was not submitted. A review of all of the critical incidents submitted by the licensee in 2018, did not include this particular incident.

The licensee failed to ensure that the Director was informed, no later than one business day after the occurrence of an incident that caused an injury to a resident that resulted in a significant change in the residents health condition and for which the resident was taken to a hospital. [s. 107. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Director was informed, no later than one business day after the occurrence of an incident that caused an injury to a resident that resulted in a significant change in the residents health condition and for which the resident was taken to a hospital, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (1) Every licensee of a long-term care home shall ensure that a written hot weather related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat. O. Reg. 79/10, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that that a written hot weather related illness prevention and management plan for the home was developed in accordance with prevailing practices and was implemented when required to address the adverse affects on residents related to heat.

According to prevailing practice entitled "The Guidelines for the Prevention and Management of Hot Weather Related Illness in Long Term Care, July 2012", developed by the Ministry of Health and Long Term Care, routine monitoring of the internal building environment for air temperature and humidity are necessary when outdoor temperatures begin to exceed 26 degrees Celsius (C). Once a humidex value (an index number that is used to describe how the weather feels to the average person when the effect of heat and humidity are combined) is between 30-39, which is a zone where most individuals would feel some discomfort, staff would need to be informed to enhance their monitoring of residents who were at risk of heat related illnesses. The guidelines include how to

take air and humidity levels, how to calculate the humidex, what actions can be taken to try and keep the building cool and other suggestions.

The licensee's policy entitled "Heat Prevention - Hot Weather (LTC-CA-WQ-200-07-05)", dated December 2017, failed to include any information or direction about the monitoring of the indoor building environment during extreme heat. No guidance was given as to how and when to take air temperatures and humidity levels, and where to take them. The policy did not identify which areas would be the designated cooling areas and whether they could each accommodate up to 40 residents [as per s. 20(2)]. The policy included more specifically what actions were to be taken with respect to residents, such as completing heat assessments, what general interventions to implement during heat alerts, what symptoms to monitor for and staff training frequency. The policy included two directives that were confusing related to when interventions would be initiated. The first statement was made on page one that resident symptoms would be monitored when "air temperature plus humidity exceeded 30C". But did not identify if that included indoor or outdoor conditions. The second statement was on page two that identified that resident's "intake and output" would be monitored when the humidex reached 40C inside the building. The air temperature plus the humidity would be known as the humidex, which does not have a degrees Celsius associated with it. Therefore the values of 30C and 40C were unclear.

A complaint (#24759-18) was received that several residents were complaining about the extensive heat in their rooms in August and September 2018. Outdoor peak temperatures during that time ranged between 28-31 degrees Celsius. The residents were located in one specified home area. According to service records, the air tempering system for the specified wing of the home failed in August 2018, and was subsequently repaired in September 2018 . Although staff and residents confirmed that the dining rooms and common areas were air conditioned at the time, no temperature and humidity values were collected of the designated cooling areas. Conversely, both values were collected by nursing staff from three resident rooms each day throughout the summer months.

According to the Environmental Services Supervisor (ESS) and several personal support workers (PSWs) during the inspection, a digital hygrometer that could sense humidity and air temperature was used and taken from resident room to resident room. No readings were collected from the dinning rooms or common spaces as staff were unaware that these areas required monitoring.

The licensee failed to ensure that that a written hot weather related illness prevention and management plan for the home was developed in accordance with prevailing practices and was implemented when required to address the adverse affects on residents related to heat. [s. 20. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that as part of the organized program of laundry services under clause 15 (1) (b) of the Act, that a sufficient supply of face cloths were always available in the home for use by residents.

A complaint (#24759-18) was received regarding a shortage of bath towels, sheets, face cloths, hand towels and bed pads in the home in July and August 2018. During the inspection, a visual confirmation was made that all supplies were adequate with the exception of face cloths. On the third floor, at approximately 1100 hours, five face cloths were noted on the first day of inspection. On the second floor, at approximately 1100 hours, no face cloths were observed on the second date of inspection. Various storage rooms, bathing rooms and resident washrooms were checked. According to five day shift PSWs and two night shift PSWs, the supply overall had improved, however during the day shift, face cloths were usually not readily available. PSWs #112 and #113 reported on the third day of inspection that they had run out of face cloths for late morning care and had to use hand towels or a bath towel earlier that day.

According to laundry aide #116 clean linens were delivered to the third floor once per day at 1430 hours and to the second floor twice per day, at 0630 and 1430 hours. The number of face cloths sent to the floors were not usually counted, but were based on how high the stack appeared when laid out flat. Face cloths that were clean and ready to go to the two floors were observed in the corridor outside the laundry room on the second

day of inspection at 1345 hours. They were counted and 60 were allocated for each floor. The third floor was allocated 60 for a 24 hour supply (all three shifts) for 57 residents and the second floor was allocated 60 cloths over the course of two shifts for 66 residents. Approximately 30 were left in the laundry room, readily available should staff request more. One face cloth was therefore available per resident on the third floor and two per resident on the second floor over a 24 hour period. According to PSWs interviewed, residents required a face cloth for morning care, before going to bed and sometimes between or after meals, depending on their needs. The PSWs also reported that some staff hoarded linens when they became available or threw them out when heavily soiled, thereby creating a constant need to replenish the supply, which they felt was not frequent enough. According to the licensee's policy entitled "Linen Quotas/Requirements to Chartwell Residence Areas" dated February 2015, a quota of four face cloths per resident was allocated and the laundry aide was to refer to the quota list when filling carts with clean linen for the resident areas.

According to the Administrator, 120 face cloths were ordered in August 27, 2018, along with other types of linens, after conducting a linen inventory count in August 2018. Twelve hundred face cloths were previously ordered in early 2018. According to the licensee's linen inventory count policy (ALL-CA-ALL-500-NESM), dated February 2015, a quarterly audit was required to ensure a daily accurate distribution of linen to meet the residents' requirements, however the Administrator reported that only one formal audit was conducted to determine linen supply levels in the building in 2018.

The licensee failed to ensure that as part of the organized program of laundry services under clause 15 (1) (b) of the Act, that a sufficient supply of face cloths were always available in the home for use by residents. [s. 89. (1) (b)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee did not ensure that all staff participated in the implementation of the infection prevention and control program.

The infection prevention and control program includes but is not limited to outbreak control measures and cleaning and disinfection procedures and frequencies. The licensee established policies and procedures related to both day to day and outbreak cleaning and disinfection procedures.

I) A written complaint (#13573-18) was received regarding the method in which bodily fluids were handled by a staff member in June 2018. On a specified day, a staff member was observed by the complainant to have used a mop to remove fecal material from the floor. The complainant witnessed the staff member while they went to retrieve a mop, mopped up the feces and then took the mop back to a utility room. The complainant stated that the staff member did not bring with them a mop bucket or a wet floor sign. When they were done mopping, the staff member walked back down the hall with the mop dripping on the floor.

According to several housekeepers, a mop and bucket were provided for nursing staff use in the dirty utility rooms should they need to clean any spills. Otherwise, the housekeeping staff used a single floor pad and not a mop when mopping floors and stated that PSWs were responsible for cleaning blood and bodily substances and that housekeeping staff would complete the disinfection process. Observations were made of the utility rooms and both a mop and bucket were present on each floor along with a wet floor sign.

According to the licensee's policy LTC-CA-WQ-205-02-02 entitled "Cleaning of Blood and Body Substances", dated January 2015, any body substances were to be wiped up using disposable towels first, followed by disinfection. A wet floor sign was to also be posted. The policy directed both nursing staff and housekeeping staff as responsible for the task.

The staff member, although a description was provided, could not be identified and verification could not be made if the individual was adequately trained and aware of the policy. Based on the details provided by the complainant, the staff member therefore did not participate in the infection prevention and control program to ensure that the floor was cleaned and disinfected after contamination in accordance with established policies.

II) During the inspection, a respiratory outbreak was active in the home that began in

December 2018, and ended in January 2019. The symptomatic residents were isolated to one of two floors. According to the home's outbreak management policy provided by the Administrator, during outbreaks, a specific procedure was to be followed twice per day. The policy did not include any information about how the additional cleaning would be achieved, whether day to day routines would change or whether additional hours would be added to the existing cleaning and disinfection routines. The policy included a statement that the cleaning would be initiated "twice per day". No specific cleaning details were included about cleaning and disinfection during the night shift or whether touch point surfaces in common areas needed to be cleaned and disinfected. According to the Administrator, the housekeeper's routine was altered so that no rooms were deep cleaned (which normally took 45 min to one hour) and the time was redirected to disinfecting contact surfaces such as door handles, door frames, light switches, window sills, bedside tables, telephone etc. One housekeeper was allocated per floor, but the Administrator mentioned that during outbreaks, especially if isolated to one floor, other housekeepers were required to assist.

Several housekeepers were interviewed during the inspection about both day to day and outbreak cleaning and disinfection tasks. Staff #111 identified that contact surfaces in resident rooms and washrooms were not always disinfected due to staff shortages and time constraints. The staff member identified that they were short staffed on two particular days in December 2018, and that very little disinfection took place. When asked if other housekeepers assisted them from other floors, the staff member reported that other housekeepers were restricted from working on multiple floors during outbreaks. Verification was made by reviewing the "Employee Daily Totals Report" that only 14 hours instead of 22.5 hours were worked by housekeeping staff on a specified date in December 2018. According to the "Employee Daily Totals Report" for hours worked in housekeeping, the total number of hours was 160.5 one week prior to the outbreak.. During a portion of the outbreak, the total number of hours was 162.

With regards to day to day cleaning and disinfection practices, staff #120 stated that one room per day received a deep cleaning, where all furnishings, walls, fixtures, windows etc. were cleaned and disinfected. One day a week, handrails, door hardware and other touch point surfaces were disinfected. Resident bedrooms received two different levels of cleaning, depending on the day, and it depended on whether a room was scheduled to be cleaned as per a "basic" or "general" routine. According to housekeeping written routines for each floor (dated November 2011), the "basic" routine included bathroom cleaning and disinfection (including touch point surfaces in and around the bathroom) and garbage removal. The "general" routine included bathroom and bedroom cleaning

and disinfection (including touch point surfaces in both rooms), floor mopping and garbage removal. The two types of routines were alternated for each room. However, during outbreaks, each resident room and washroom was to receive a general cleaning, twice per day. If interpreted correctly, each of the 28 rooms on the third floor would have needed to have been generally cleaned twice, including the common areas (dining room, lounge) and utility rooms at least once. Within the allocated 7.5 hours provided to one housekeeper to perform these duties, it was determined to be impossible to carry out the duties as specified in the outbreak policy.

The cleaning and disinfection procedures and frequencies were developed such that staff could not participate in implementing them and/or the licensee did not ensure that staff participated in their implementation. According to Public Health Ontario's "Best Practices for Environmental Cleaning for Infection Prevention and Control in All Health Care Settings", April 2018, the licensee did not ensure that the program related to cleaning and disinfection was developed to ensure that:

*Environmental service workers could adhere to their policy on cleaning and disinfection frequency.
*There was sufficient staffing and resources to allow thorough and timely cleaning and disinfection.
*There was sufficient staffing and resources to allow for provision of additional environmental cleaning capacity during outbreaks that did not compromise routine cleaning of any clinical areas or client/patient/resident rooms

The licensee did not ensure that all staff participated in the implementation of the infection prevention and control program. [s. 229. (4)]

Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d’inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Issued on this 13th day of February, 2019

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.