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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: July 30, 2024
Inspection Number: 2024-1272-0004
Inspection Type: Complaint Critical Incident
Licensee: Collingwood Nursing Home Limited
Long Term Care Home and City: Collingwood Nursing Home, Collingwood

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 8, 9, 10, 2024
The inspection occurred offsite on the following date(s): July 11, 2024

The following intake(s) were inspected:
- Anonymous complaints regarding mould in the home.
- Critical incident submitted regarding mould in the home.

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Training

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 82 (2) 10.

Training

s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.

The licensee failed to ensure that the Maintenance Manager (MM) received training before performing their responsibilities. Specifically, training related to the policies of the licensee, that were relevant to the person's responsibilities related to the accommodation services program under Ontario Regulation 246/22.

Rationale and Summary

The MM began their employment in December 2023, and was required to manage and monitor operational systems, complete preventive maintenance tasks, and ensure the building, equipment and furnishings were maintained in good repair. The MM reported that they did not receive access to any maintenance policies and procedures developed by a management and clinical consulting company hired by the licensee. Their training consisted of a tour of the home by the owner/administrator for approximately 15 minutes, and a one-hour orientation eleven days after their start date by the Manager of Building Services from the management consulting company. Shortly after being hired, the MM oriented themselves to the building and equipment and made assumptions based on some experience as to the work tasks that needed to be completed.

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The lack of an organized orientation and training program for the MM position has resulted in a lack of awareness of the responsibilities of the maintenance role and contributed to unsatisfactory maintenance issues in the home.

Sources: Interview with the Maintenance Manager (MM) and Director of Building Services (external management consulting company), review of orientation and training documentation for the MM.

WRITTEN NOTIFICATION: Communication and response system

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 20 (g)
Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system (RSCRS) that,
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff.

Rationale and Summary
The RSCR system in the home did not include audio components in the corridors, especially near the ends of each of the 3 corridors, to ensure that staff could hear the system when used by residents or staff. The sole source of sound came from a panel at the nurse's station which was determined to be insufficient.

Failure to equally distribute or calibrate the audio throughout the home may contribute to a delayed response by staff to any alerts.

Sources: Observations based on testing of the system.

COMPLIANCE ORDER CO #001 Housekeeping

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

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

The licensee must be compliant with FLTCA, 2021, s. 19 (2) (c)
Specifically, the licensee must:

1. Hire an identified cleaning service provider or another professional cleaning service to thoroughly clean the following at a minimum: all kitchen fixed tables, shelving, stove, walls, flooring, walk-in cooler flooring, walls, floors and storage racks, dried goods storage room floor (followed by stripping and re-waxing), dishwasher, dishwasher area floor, grease trap, walls, fixtures, and fixed equipment (which includes legs and undersides), and exterior of both walk-in cooler and walk-in freezer. The cleaning shall be completed at times that will not impact meal preparation for residents.

2. Conduct a monthly audit of the kitchen, dishwash area and dried goods storage room by the dietary manager or designate to ensure that it remains clean and sanitary. The audits shall be kept for a minimum of one year.

3. Thoroughly clean the servery and dining room walls where visible matter is evident.

4. Assign dedicated staff to clean the dining room walls as often as needed and include the task in applicable procedures and schedules.

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5. Develop a deep cleaning schedule that includes the walk-in cooler and freezer and allocate adequate staffing hours each month to complete these spaces and all other kitchen and storage area cleaning requirements.
6. Hire an identified cleaning service provider or another professional cleaning service specializing in floor care to thoroughly strip remnants of old flooring wax and other build-up from the flooring in resident rooms, common areas, corridors, and dining room. The floors shall be cleaned and sealed thereafter.
7. Develop a floor cleaning schedule identifying which space will be deep cleaned and when. The schedule and information regarding how resident's personal belongings and furnishings will be managed during the process shall be shared with staff, residents and families before the process begins.
8. Implement and comply with the current cleaning service provider's floor care procedures and include the completion of routine audits of the floor care program once the above noted stripping and sealing process has been completed.

Grounds

The licensee has failed to ensure that the home and equipment were kept clean and sanitary.

Rationale and Summary

The following observations were made at the time of inspection:

• Heavy build-up of grease and food debris around and under all fixed equipment in the kitchen and dishwash area, especially around the grease trap and under dishwasher.

- Heavy build-up of visible matter on the walk-in cooler floor, and on storage racks.
- Heavy build-up of old floor wax in the dried goods storage room, most resident rooms, common area and other areas of the home.
- Build-up of encrusted food debris on the dishwasher, visible matter on the surfaces of kitchen walls, exterior surfaces of walk -in cooler and freezer, on storage equipment and cooking stove in the kitchen.
- The dining room wall under the menu was visibly soiled and along the dining room side of the servery counter.

The dietary manager was not available in the home during the inspection and could not speak to the state of the kitchen, dried goods storage room and dishwash area. Cleaning schedules and procedures were available, but the deep cleaning schedule did not include the walk-in cooler. Staff marked off that the daily cleaning tasks were being completed but a determination could not be made as to how many hours per week were spent on deep cleaning. Sanitation audits were not available to determine if cleaning tasks were completed, whether the cleaning program was sufficiently staffed and what improvements were required. Dietary and housekeeping staff both identified that they were not responsible for cleaning dining room walls. The procedure for cleaning dining rooms did not identify specifically who was responsible.

The licensee outsourced the housekeeping staff and services from an identified cleaning service provider. According to their floor care policies and procedures, floors were to be stripped, re-waxed and buffed at specified frequencies. According to the housekeeping manager, the procedures and frequencies could not be followed due to a lack of appropriate equipment, staffing to complete the tasks and approval by the licensee.

Failure to keep the home and equipment clean and sanitary increases the likelihood of disease transmission.

Sources: Observations, review of dietary cleaning schedules, policies and procedures and interview with the housekeeping manager.

This order must be complied with by September 30, 2024

COMPLIANCE ORDER CO #002 Maintenance services

NC #004 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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.

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

The licensee must be compliant with O. Reg. 246/22, s. 96 (1) (b).

Specifically, the licensee must;

1. Develop written preventive maintenance procedures that are home-specific to Collingwood Nursing Home for furnishings, fixtures, equipment, operational systems (hot water and potable water supply, cooling, heating, ventilation, resident staff communication and response system, fire safety systems, lighting, drainage, door access control systems), and surfaces (roof, doors, walls, floors, windows, ceilings).

2. Include in each procedure a minimum of the following information:

a) Who is responsible for monitoring the equipment, surface, fixture, furniture, surfaces, or system (whether home staff or an external service provider) and how often;

b) What forms or checklists are to be completed to assist with any monitoring task

c) What the staff member is required to do, observe or test based on their skill level and manufacturer's requirements;

d) The required or acceptable condition of the equipment, surface, fixture, furniture, or system (derived from the manufacturer, prevailing or best practices, building, electrical & fire code requirements, CSA standards, etc.);

e) Follow up requirements if an unacceptable condition is identified and any documentation requirements;

f) Acceptable time frames, based on risk, for repair or replacement; and

g) Any additional tasks as required to maintain the fixture, surface, equipment, system, and furniture in a good state of repair.

3. Develop an audit or checklist that includes all of the spaces in the home. Each space shall be inspected routinely for condition and include the surfaces, fixtures, equipment, and furnishings in each space. Any deficiencies identified shall be dated and an action plan developed to address the deficiency.

4. Conduct an audit of the resident rooms, all washrooms, common areas and utility rooms using the developed audit form or checklist to determine what additional deficiencies require attention that have not been identified in the grounds below. The audit results shall be maintained for one year and include who conducted the audit(s), what was identified, the date of the audit(s), course of action that was taken to address the deficiency and the date the deficiency was resolved.

5. Provide the inspector (via email) with an action plan that lists the deficiencies identified in the grounds below and include who will be responsible for addressing the maintenance deficiencies and the proposed allocated time to complete the work.

Grounds

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

In accordance with O. Regulation 246/22, s. 11(1) (a), the licensee is required to ensure that the procedures and schedules are in compliance and implemented in accordance with applicable requirements under the Act, specifically s. 19(1)(c).

Rationale and Summary

The licensee adopted over a year ago, maintenance procedures and schedules from an external service provider who offered consulting and management services.

The service provider's maintenance-related policies included general information as to what processes, systems, records, and procedures the licensee should have in place. In addition, some of the written procedures included tasks and schedules for the licensee to implement for some operational systems and equipment, but did not include the home's furnishings, surfaces, fixtures, or all equipment. It was up to the licensee to develop home-specific written procedures. The licensee purchased a software program identified as "Maintenance Care" which included the ability for staff to enter information related to disrepair, and scheduled tasks for the maintenance employee to complete, but it was not all encompassing.

No documented preventive maintenance audits had been completed in 2024 to determine the condition of the home and plans for repairs.

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Observations included missing sections of wall board in a resident room backing onto a soiled utility room, which had been removed due to mould growth. Remediation by a professional company was pending for the area and several other areas that were identified to have mould growth. Other observations included;

• Resident night tables with exposed particle board along the top front and side edges

• Rusty sink drains, rust in or on edges of vanity sinks

• Water-stained ceiling tiles from multiple and on-going leaks from the roof (An identified resident room had a visible black substance resembling mould on ceiling tile next to an air conditioner located inside the ceiling space).

• Peeling or missing baseboards in resident rooms or washrooms. One in a closet in an identified resident room was lying on the floor, and small amounts of mould were observed on the wall board. Mould was noted behind baseboards in an identified resident room and a staff washroom. Noted excessive water on floor when staff mopping, and water left to sit up against baseboards. This practice contributes to water getting up and under baseboards causing mould to grow on wall boards.

• Unpainted or peeling interior windowsills.

• Dust clogged exhaust grilles in various areas in the home

• Damaged flooring material in the kitchen, dishwash area and tub room. Water penetration evident under flooring in kitchen. Flooring material lifted in and identified resident washroom.

• Resident-staff communication and response system panel at nurse’s station continuously sounding.
• Non-functional light ballasts.

- Cracked curb sinks in the dishwash area, housekeeping room, one of which leaked into a wall cavity, causing mould to grow.
- Hand wash sink in tub/shower room not adequately secured to wall.
- Hole in wall beside hand wash sink in kitchen.
- Low water pressure and toilets that could not flush well

Failure to develop, implement and comply with the maintenance program schedules and procedures has created adverse conditions in the home which does not align with the fundamental principle under the Fixing Long Term Care Act to promote high quality accommodation to live in a safe and comfortable environment.

Sources: Observations, interview with the maintenance supervisor, owner/administrator, Director of Building Services (Universal Care), housekeeping supervisor, review of "Daily Rounds Inspection Policy (14070234), Preventive Maintenance Schedule (14070754), Preventive Maintenance Policy (14070549), Daily Ongoing Maintenance (14070250) Maintenance Care software program.

This order must be complied with by October 28, 2024

COMPLIANCE ORDER CO #003 Infection prevention and control program

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee must be compliant with O. Reg. 246/22, s. 102 (2) (b)

Specifically, the licensee must;

1. Develop a written policy and procedure, in consultation with the home's IPAC lead, that deals with how to handle, store and clean and disinfect non-critical reusable medical devices such as wash basins, bed pans, urinals and commode pots in accordance with any of the following best practices Frequently Asked Questions (FAQ) on Bath Basin Use in Long-Term Care Facilities | Agency for Healthcare Research and Quality (ahrq.gov), PIDAC: Best Practices for Environmental Cleaning for Prevention and Control of Infections | January 2018 (publichealthontario.ca) page 140 and WRHA Infection Prevention & Control Program.
2. Once developed, all care staff who use the reusable medical devices shall receive face to face training and any demonstrations with respect to the written policy and procedure. Maintain an attendance list, date and time training was provided and who provided the training.
3. Develop an audit form that includes what practices, products and supplies the IPAC lead or designate will be required to review related to the handling, storage, cleaning and disinfecting of non-critical reusable medical devices by care staff in resident spaces and in soiled utility rooms.
4. Complete the audit form quarterly and maintain the records for review.

Grounds

The licensee has failed to implement the Infection Prevention and Control (IPAC) Standard (revised September 2023) issued by the Director.

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Specifically, sections 5.3 (h), 5.8 and 7.3 (b) of the IPAC Standard were not implemented.

Rationale and Summary

Section 5.3 (h) requires that the IPAC program include cleaning and disinfecting policies and procedures related to implementing routine practices. Routine practices includes cleaning and disinfecting resident's reusable medical equipment (e.g., basins, urinals, commodes, bed pans, etc.). The licensee identified that they referred to procedures developed by their consulting and management service. After an extensive search and consultation with the Director of Clinical Services for the company, none could be located.

Three personal support workers were not aware of the best practices related to cleaning and disinfecting reusable medical equipment. The wash basins were normally rinsed and allowed to air dry after each use. No specific cleaning and disinfection process was employed. During the inspection, wash basins and bed pans were observed stored inappropriately on towel and grab bars in resident washrooms, and some did not appear clean. No disinfection products were made readily available to care staff while in resident care areas.

Failure to develop and implement cleaning and disinfection procedures for staff to follow increases inconsistent routine practices and the risk of disease transmission.

Section 5.8 requires the licensee to make every effort to eliminate the use of hoppers and limit the carrying of reusable medical equipment to another location for emptying. The best practice is to empty the contents of bed pans into the resident's toilet or use bed pan absorbent liners.

During the inspection, a personal support worker traveled from a room to the soiled utility room down a corridor carrying a bed pan full of body fluids with a foul odour. The employee was observed dumping the contents into the hopper and used the

hopper to rinse the soiled bed pan. The bed pan was then returned to the resident's room.

PSWs who were interviewed reported that they were aware of the need to use the resident's toilet to dispose body fluids but could not do so in every washroom. The toilets were not able to fully flush the contents, therefore necessitating staff to use the hopper.

Four ensuite washroom toilets were tested and each washroom had a different model of toilet. One toilet in an identified washroom could not flush properly as the tank was equipped with a water saving trough. The trough filled up instead of the tank, thereby reducing the water volume by 50%. When the toiled was flushed, very little water was available to flush anything more than urine. Other toilets had small, insulated tanks to conserve water, and did not flush well.

Hand sinks were noted to have low water pressure. Personal support workers reported that some rooms had worse water pressure than others and that filling the tubs took an unreasonable amount of time.

According to the Town of Collingwood Water Services Department, the amount of pressure to the building was measured to be 20 pounds per square inch (PSI) in July 2024. A booster pump would be required to ensure a normal water pressure of 40-80 PSI.

The carrying of body fluids out of a resident care space increases the risk of disease transmission.

Section 7.3 requires the IPAC lead to perform (at least quarterly) audits to ensure that all staff can perform the IPAC skills required of their role. The IPAC lead acknowledged that they did not perform audits regularly to determine if personal support workers were cleaning and disinfecting reusable medical devices, as required by their role.

Failure to conduct quarterly audits to determine if care staff are cleaning and disinfecting reusable medical equipment (which is part of the role of personal support workers) in accordance with best practices increases the risk of disease transmission.

Sources: Observations, and interview with the IPAC lead, Director of Clinical Services for a consulting and management service and personal support workers.

This order must be complied with by August 26, 2024

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.