

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

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée* 

#### Ministry of Health and Long-Term Care

Health System Accountability and Performance Division Performance Improvement and Compliance Branch

## Ministère de la Santé et des Soins de longue durée

Division de la responsabilisation et de la performance du système de santé Direction de l'amélioration de la performance et de la conformité Hamilton Service Area Office 119 King Street West, 11<sup>th</sup> Floor Hamilton ON L8P 4Y7

Telephone: 905-546-8294 Facsimile: 905-546-8255 Bureau régional de services de Hamilton 119, rue King Ouest, 11iém étage Hamilton ON L8P 4Y7

Téléphone: 905-546-8294 Télécopleur: 905-546-8255

	Licensee Copy/Copie du Titulaire Public Copy/Copie Public			
Date(s) of inspection/Date de l'inspection	Inspection No/ d'inspection	Type of Inspection/Genre d'inspection		
April 13, 2011	2011-120-2847-13Apr144644	H-00855-11 – Follow-up		
Licensee/Titulaire				
Extendicare (Canada) Inc., 3000 Steeles Avenue East, Suite 700, Markham, ON L3R 9W2  Long-Term Care Home/Foyer de soins de longue durée  Extendicare Brampton, 7891 McLaughlin Road, Brampton, ON L6Y 5H8  Name of Inspector(s)/Nom de l'inspecteur(s)  Bernadette Susnik, Environmental Health #120				
Inspection Summary/Sommaire d'inspection				
The purpose of this visit was to conduct a follow-up inspection to previously issued non-compliance made under the Ministry of Health and Long Term Care Homes Program Standards Manual related to unmet criteria:  • M3.21 (Infection Prevention and Control)				

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During the course of the inspection, the inspector spoke with the Director of Care, Assistant Director of Care, and Food Services Supervisor. During the course of the inspection, the inspector conducted a walk-through of resident bedrooms, ensuite washrooms, dining rooms, serveries and bathing rooms.

The following Inspection Protocols were used during this inspection:

- · Accommodation Services Housekeeping
- Infection Prevention and Control

P1.23 (Food Temperatures)

Food Quality

Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN 3 VPC



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#### NON- COMPLIANCE / (Non-respectés)

#### Definitions/Définitions

WN – Written Notifications/Avis écrit
 VPC – Voluntary Plan of Correction/Plan de redressement volontaire

DR - Director Referrat/Régisseur envoyé

CO – Compliance Order/Ordres de conformité

WAO - Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le sulvant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le Loi de 2007 les foyers de soins de longue durée à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The licensee has failed to comply with the LTCHA 2007, S.O., 2007, s.15(2)(a). Every licensee of a long-term care home shall ensure that,

(a) the home, furnishings and equipment are kept clean and sanitary and;

Previously issued as criteria M3.21 under the Ministry of Health and Long Term Care Homes Program Standards Manual.

#### Findings:

- Visible residues were noted on many of the cabinetry surfaces (both on the outside and on the inside) in resident ensuite washrooms. Visible matter also noted on the exterior surface of many hand sinks, along the underside towards the top of the cabinetry.
- Serveries in all 6 home areas were noted to have visible matter stuck to the walls (under the fixed tables and above the garbage area) and on doors.

#### **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 home, furnishings and equipment are kept clean and sanitary, to be implemented voluntarily.

WN #2: The licensee has failed to comply with O. Reg. 79/10, s. 229. The licensee shall ensure that all staff participate in the implementation of the program.

Previously issued as criteria M3.21 under the Ministry of Health and Long Term Care Homes Program Standards Manual.

#### **Findings:**

Staff members are not participating in the infection prevention and control program, which includes the prevention or the elimination of the spread of disease through cleaning and disinfection processes. The following was noted:

The home's policy with respect to the residents' personal care articles such as washbasins, urinals and bed pans requires staff to bring soiled items after use to the soiled utility room where they can be processed (cleaned and disinfected) after each use. It was determined that staff are not adhering to this process and are instead leaving the personal care article in the resident's washroom cabinet, with water in it and in some cases, with residues on the item.



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### **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 all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #3: The licensee has failed to comply with O. Reg. 79/10, s. 72(3(b). The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,

(b) prevent adulteration, contamination and food borne illness.

Previously issued as P1.23 under the Ministry of Health and Long Term Care Homes Program Standards Manual. Findings:

Pureed lasagna stored in a pan inside of a steam well in the Chingaucousy home area servery was measured to be 41°C at 12:39 p.m. At 1:00 p.m. it was measured at 40°C. The staff member serving the pureed lasagna did not take appropriate actions or use other methods in order to ensure that hot food remained hot throughout the meal service. The water level in the steam well was noted to be very low and very little steam was eminating from the well towards the front. The foods stored in the well towards the back (towards the sneeze guard) were over 60°C. Bacterial multiplication begins to occur in hazardous foods such as those containing meat and cheese, when temperatures fall below 60°C. This may lead to food-borne illness. In addition, residents who are expecting a hot meal would find the pureed lasagna to be unpalatable.

Tuna fish sandwiches were noted to be stored out at room temperature, in a stainless steel pan, which sat on top of ice cubes, on the counter in both the Heart Lake and Chingaucousy home area serveries. The sandwiches in both serveries were measured to be 10°C. Bacterial multiplication in hazardous foods such as tuna fish sandwiches begin to multiply above 5°C, potentially causing food-borne illness.

#### **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 all food and fluids in the food production system are prepared, stored and served using methods to prevent food borne illness, to be implemented voluntarily.

Signature of Licensee or Representative of Licensee Signature du Titulaire du représentant désigné		Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.	
		B. Susnik	
Title:	Date:	Date of Report (if different from date(s) of inspection).	