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
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Public Report

Report Issue Date: December 13, 2024

Inspection Number: 2024-1401-0008

Inspection Type:
Complaint
Critical Incident

Licensee: Steeves & Rozema Enterprises Limited

Long Term Care Home and City: Lanark Heights Long Term Care Centre, Kitchener

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 9, 10, 2024

The following was inspected:

- Critical incident report related to an Acute Respiratory Outbreak.
- Complaint regarding aspects of the Infection Prevention and Control Program.

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

Infection Prevention and Control
Safe and Secure Home

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 5
Home to be safe, secure environment
s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents.

The licensee has failed to ensure that the home was a safe environment for its residents.

Electrical appliances such as a microwave oven and a toaster were readily available and functional in the Oak home area dining room for staff, resident, and family use. Microwave ovens were also noted in all of the other four dining rooms. None of the electrical appliances were connected to a power deactivation switch or had a lock out feature for safety, as required for LTC homes built after 1999 (as per the 1999 LTC Home Facility Design Manual).

Sources: Observations, review of the LTC Home Facility Design Manual, 1999, and interview with the Administrator.

The licensee removed all microwaves and toasters from the dining rooms on December 10, 2024.

Date Remedy Implemented: December 10, 2024

WRITTEN NOTIFICATION: Housekeeping

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (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,

As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee failed to ensure that procedures were developed and subsequently implemented for cleaning and disinfection of non-critical resident care devices (wash basins, bed pans), using a low-level disinfectant in accordance with evidence-based practices.

As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee failed to ensure that procedures were developed and subsequently implemented for cleaning and disinfection of resident care equipment (such as wash basins, bed pans), using a low-level disinfectant in accordance with evidence-based practices.

Specifically, procedures were not developed related to handling, washing, disinfecting, storing and when to discard wash basins or bed pans which are considered non-critical medical devices or resident care equipment.

Wash basins were observed in six different resident ensuite washrooms with pooled water on the bottom and basins in two different resident ensuite washrooms had water scale residues. The observed condition of the basins was an indicator that basins were not wiped dry and subsequently disinfected after use, as per evidence-based practices. No supplies or provisions were made available for staff to clean and disinfect the basins in resident ensuite washrooms. The Infection Prevention and Control (IPAC) lead identified that the soiled utility rooms were the alternate location for processing, however the direction and specific details regarding how to clean and disinfect and handle bed pans and wash basins was not included in the existing procedure developed by the licensee.

Care staff were not observed to use the soiled utility rooms for cleaning and disinfecting the wash basins during the inspection.

Sources: Observations, interview with the IPAC Lead, review of cleaning and disinfection policy and procedure ICM 02-03 and Best Practices for Environmental Cleaning for Infection Prevention and Control (2018).