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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: February 14, 2024	
Original Report Issue Date: February 8, 2024	
Inspection Number: 2024-1320-0001 (A1)	
Inspection Type: Critical Incident	
Licensee: Orillia Long Term Care Centre Inc.	
Long Term Care Home and City: Leacock Care Centre, Orillia	
Amended By Bernadette Susnik (120)	**Inspector who Amended Digital Signature** Bernadette Susnik Digitally signed by Bernadette Susnik Date: 2024.02.21 15:17:30 -05'00'

AMENDED INSPECTION SUMMARY

This report has been amended. NC#008 and CO #001 related to NC#009 were removed from the report.

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Lead Inspector Bernadette Susnik (120)	**Additional Inspector(s)**
Amended By Bernadette Susnik (120)	**Inspector who Amended Digital Signature** Bernadette Susnik Digitally signed by Bernadette Susnik Date: 2024.02.21 15:18:07 -05'00'

AMENDED INSPECTION SUMMARY

This report has been amended. NC#008 and CO #001 related to NC#009 were removed from the report.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 8-10, 2024
The inspection occurred offsite on the following date(s): January 15, 18, 19, 22, 23, 25, 2024

The following intake(s) were inspected:

- Intake related to an Environmental Hazard
- Intake related to an Enteric Outbreak

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

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

AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Specific duties re cleanliness and repair

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (a)
Accommodation services
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 licensee has failed to ensure that the home, furnishings, and equipment were kept clean and sanitary.

Rationale and Summary
The main kitchen and a servery were not maintained in a clean and sanitary state. Visible accumulation of matter noted on various surfaces such as walls, flooring, ceiling, equipment, and appliances. Several lounge chairs and windows in some areas of the home were observed to be visibly soiled.

Job routines, daily and deep cleaning schedules and a manager's walk-through checklists were developed for all equipment and surfaces of the kitchen and serveries but were not fully implemented.

Sources: Observation, interview with the Culinary Manager, Nutra Services VP of

Operations, Superior Housekeeping Supervisor, dietary staff and review of job descriptions, cleaning schedules and checklists. [120]

WRITTEN NOTIFICATION: Air temperature

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (1)
Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

The licensee has failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius.

Rationale and Summary
The licensee's fresh air make up unit was required to be shut off for a period of three days for one area of the building. The licensee's primary source of heat, which included hot water radiators was not affected. The licensee reported that air temperature monitoring frequency was increased in the affected home area to ensure resident safety.

On a specified date, an identified resident room was consistently at 20 or 19˚C all day but no temperatures were taken during the night shift. On another date, a different resident room was 18˚C all day but no temperatures were taken during the night shift. Other resident rooms were not included on the temperature log.

A review of the air temperature logs revealed that various areas of the home were not maintained at 22˚C or greater for an entire specified month.

Failure to monitor air temperatures and ensure they remain at or above 22˚C (unless otherwise requested by a resident) may lead to resident discomfort and/or

increased safety risks.

Sources: Review of air temperature logs, interview with the administrator. [120]

WRITTEN NOTIFICATION: Air temperatures

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (3)
Air temperature
s. 24 (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The licensee has failed to ensure that the air temperature that was to be measured in various areas of the home as per subsection (2) was documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Rationale and Summary
Air temperature records for a specified month in 2023, revealed that staff were not documenting any air temperatures on some days or documenting only once or twice per day, and not on all three shifts. The administrator noted that readings were taken once per shift during the summer months only.

Failure to ensure that air temperatures are monitored on each shift may lead to resident complaints, resident discomfort and a delay in recognizing when heating equipment has malfunctioned.

Sources: Air temperature logs, interview with the administrator. [120]

WRITTEN NOTIFICATION: Housekeeping

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (ii)
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:
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and

As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee has failed to ensure that procedures were developed and implemented for cleaning and disinfecting resident non-critical personal care equipment in accordance with evidence-based practices.

Rationale and Summary
The licensee's current procedures were not developed in accordance with evidence-based practices from Public Health Ontario with respect to the frequency of disinfecting non-critical resident care equipment (devices). Best Practices for Environmental Cleaning for Prevention and Control of Infections in all Health Care Settings, April 2018 identifies cleaning and disinfecting wash basins after each use.

The licensee's existing or previous procedure titled Cleaning and Disinfecting Resident Care Equipment dated May 23, 2023, and which staff were to follow, directed staff to clean wash basins before and after use. No disinfection step was included unless the basin was shared with another resident.

The corporate IPAC lead reported that their amended cleaning and disinfection procedure for wash basins was developed on November 1, 2023, and had not yet been implemented with staff. The procedures required care staff to wash, rinse and dry wash basins followed by disinfection with a disposable disinfectant wipe after each use completed in resident washrooms. A deep cleaning and disinfection process was required once per week using a liquid disinfectant in the soiled utility room.

Failure to implement and ensure adherence to cleaning and disinfection procedures for non-critical resident care equipment (devices) may contribute to the spread of infectious organisms, outbreaks or a delay in controlling the duration of outbreaks.

Sources: Interview the corporate IPAC Lead, Associate Director of Care, Director of Care, care staff, observations, review of Best Practices for Environmental Cleaning for Prevention and Control of Infections in all Health Care Settings, April 2018 and Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment/Devices in All Health Care Settings, May 2013, IPAC Standard, September 2023, Jarlette cleaning and disinfecting procedures (Standard Operating Procedure – Wash Basin Cleaning Process November 1, 2023, Cleaning and Disinfecting Resident Care Equipment dated May 23, 2023). [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 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

The licensee has failed to ensure that all staff participated in the implementation of the program, specifically for an enteric outbreak.

Rationale and Summary
The licensee had an enteric outbreak related to norovirus that was declared by public health.

Several outbreak control measures were not implemented at the start of the outbreak to decrease the length and extent of the outbreak. These measures were identified in the licensee's enteric outbreak management policies and procedures.

Outbreak control measures that were not implemented in a timely manner included the following;

1. Communication of suspected resident cases to public health was delayed.
2. Cohorting of staff to their specific home areas to limit the spread of the infection was delayed.
3. The process of contacting ill staff to determine if they met the case definition, if they had contact with others or knew what precautions to take was delayed.
4. The collection of specimens to determine type of organism responsible for the outbreak was delayed.

Failure to implement outbreak control measures early contributed to unnecessary resident and staff illnesses, prolonged the length and extent of the outbreak and placed a strain on human resources.

Sources: Observations, record review of resident progress notes, enteric line listing, hospital admission records, visitor logs, enteric outbreak management policies and procedures, and interview with registered staff, non-registered staff, the Director of Care, IPAC lead, Corporate IPAC lead, Administrator, Public Health Nurse from the

Simcoe Muskoka District Health Unit.

WRITTEN NOTIFICATION: Reporting re critical incidents

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 1.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
1. An emergency within the meaning of section 268, including fire, unplanned evacuation or intake of evacuees.

The licensee has failed to ensure that the Director was immediately informed, in as much detail as is possible in the circumstances, of an emergency within the meaning of section 268 (15).

Rationale and Summary
The licensee submitted a critical incident report to the Ministry of Long-Term Care of an environmental hazard, specifically a loss of essential services (heat). Although the report for an environmental hazard requires submission on the next business day and was submitted as required, the details of the incident in the report referred to both an external gas leak and possible exposure to carbon monoxide, both of which are considered emergencies as defined under s. 268 (15), and not an environmental hazard.

The licensee did not contact the Ministry immediately to report the emergency.

Sources: Review of the critical incident report and interview of the Director of Care. [120]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that the Director was immediately informed, in as much detail as is possible in the circumstances, of a communicable disease outbreak as defined in the Health Protection and Promotion Act.

Rationale and Summary
The licensee submitted a critical incident report to the Ministry of Long-Term Care related to an enteric outbreak. The outbreak was declared by their local public health unit one day prior. The licensee did not contact the Ministry immediately to report the outbreak.

Sources: Review of the critical incident report, interview with the Director of Care. [120]

(A1)
The following non-compliance(s) has been amended: NC #008
s. 268(3) was originally issued but has been determined to be compliant and has been removed from the report.

WRITTEN NOTIFICATION: Emergency plans

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 268 (4) 1. x.
Emergency plans
s. 268 (4) The licensee shall ensure that the emergency plans provide for the following:
1. Dealing with emergencies, including, without being limited to,
x. gas leaks,

The licensee has failed to comply with their emergency plan, specifically in dealing with a gas leak.

In accordance with O. Reg. 246/22, s. 11. (1) (b) the licensee is required to ensure that plans dealing with gas leaks are complied with. Specifically, staff did not contact the gas company, emergency services and the administrator or designate when a gas odour was detected.

Rationale and Summary
The licensee informed the Ministry that gas had leaked from a main gas line on the roof and had entered the home via a make-up air handling unit on a specified date. One staff member confirmed that they smelled the typical odour of natural gas when they first arrived at the home and informed registered staff. The registered staff member did not follow the written direction as per their emergency response plan.

Failure to comply with an emergency plan related to a gas leak may increase the risk of serious injury or death for residents and other occupants.

Sources: Record review of the licensee's emergency plan *Air Emergency/Shut down: Gas Leak,* correspondence from the Orillia Fire Department, interview with the

administrator, Environmental Services Supervisor, registered staff, and non-registered staff. [120]