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: February 15, 2024	
Inspection Number: 2024-1476-0002	
Inspection Type: Critical Incident (CI)	
Licensee: Schlegel Villages Inc.	
Long Term Care Home and City: The Village at University Gates, Waterloo	
Lead Inspector Katherine Adamski (#753)	**Inspector Digital Signature** Katherine Adamski Digitally signed by Katherine Adamski Date: 2024.02.15 15:39:20 -05'00'
Additional Inspector(s) N/A	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 9, 12, 13, 2024

The following intake(s) were inspected:

- Intake: #00106703/IL-0121995-AH/CI #3048-000003-24 - related to Infection Prevention and Control

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

Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Housekeeping

NC #001 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 implemented for the disinfection of the tubs and shower chairs in accordance with manufacturer's specifications and using, at a minimum, a low-level disinfectant in accordance with evidence-based practices.

Rationale and Summary

The home's Spa and Whirlpool Tub and Tubs, Shower Chairs and Commodes policy directed staff to clean and disinfect the shared resident equipment according to the manufacturer's instructions including ensuring that contact time was maintained. The manufacturer's instructions were to be available in each spa room for easy reference. Any malfunctioning equipment was to be reported immediately.

Staff on the Wright, Pollock and Matthews Neighborhoods were not adhering to the manufacturer's instructions for disinfecting the tubs or shower chairs in the home including using incorrect product, and not allowing the product to remain on the surface for the required contact time to ensure it was effective.

The manufacturer's instructions were not available in the Pollock and Matthews spa room for easy reference.

The tub in the Wright spa room was malfunctioning, which impacted the staff's ability to disinfect it as per the manufacturer's instructions, and this was not reported to management.

When the manufacturer's specifications for cleaning and disinfecting the tub were not implemented, this increased the risk of spreading infectious disease between residents.

Sources: Observations on Pollock, Matthews, and Wright (February 9, 12, 23, 2024), Spa and Whirlpool Tub Policy (Tab 06-24), Tubs, Shower Chairs and Commodes Policy (Tab 06-30), Manufacturer's Instructions (3M™ Quat Disinfectant Cleaner Concentrate, VERT-2-GO SABER, Arjo System 2000, RR7-11 Atlantic Operating and Disinfecting Procedures), interviews with the IPAC Lead and other staff.