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

# Amended Public Report Cover Sheet (A1)

| | |
|---|---|
| **Amended Report Issue Date:** November 30, 2023 | |
| **Original Report Issue Date:** November 10, 2023 | |
| **Inspection Number:** 2023-1703-0004(A1) | |
| **Inspection Type:**<br>Complaint<br>Critical Incident<br>Follow up | |
| **Licensee:** CVH (No. 3) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.) | |
| **Long Term Care Home and City:** Southbridge Owen Sound,Owen Sound | |
| **Amended By**<br>Gurvarinder Brar (000687) | **Inspector who Amended Digital Signature**<br>Gurvarinder K Brar Digitally signed by Gurvarinder K Brar Date: 2023.12.04 10:29:19 -05'00' |

## AMENDED INSPECTION SUMMARY

This report has been amended to extend the Compliance Due Date November 30, 2023 for CO #002 to December 08, 2023.

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

# Amended Public Report (A1)

| | |
|---|---|
| **Amended Report Issue Date:** November 30, 2023 | |
| **Original Report Issue Date:** November 10, 2023 | |
| **Inspection Number:** 2023-1703-0004 (A1) | |
| **Inspection Type:**<br>Complaint<br>Critical Incident<br>Follow up | |
| **Licensee:** CVH (No. 3) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.) | |
| **Long Term Care Home and City:** Southbridge Owen Sound, Owen Sound | |
| **Lead Inspector**<br>Katy Harrison (766) | **Additional Inspector(s)**<br>Helene Desabrais (615)<br>Sharon Perry (155)<br>Bernadette Susnik (120) |
| **Amended By**<br>Gurvarinder Brar (000687) | **Inspector who Amended Digital Signature**<br>Gurvarinder K Brar Digitally signed by Gurvarinder K Brar Date: 2023.12.04 10:32:53 -05'00' |

## AMENDED INSPECTION SUMMARY

This report has been amended to extend the Compliance Due Date November 30, 2023 for CO #002 to December 08, 2023.

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 12, 13, 16-20, 24-26, 2023
The inspection occurred offsite on the following date(s): October 18-20, 25, 31, 2023

The following intake(s) were inspected:
- Intake: #00095806 - Follow-up #: 1 - O. Reg. 246/22 - s. 12 (1) 1. ii.
- Intake: #00095807 - Follow-up #: 1 - FLTCA, 2021 - s. 24 (1)
- Intake: #00095808 - Follow-up #: 1 - O. Reg. 246/22 - s. 53 (1) 4.
- Intake: #00095809 - Follow-up #: 1 - FLTCA, 2021 - s. 6 (1) (c)
- Intake: #00095927 - Complaint related to multiple care concerns
- Intake: #00098717 - Complaint related to multiple care concerns
- Intake: #00098762 - Complaint related to multiple care concerns and Housekeeping Services
- Intake: #00098853 - IL-18366-CW, Complaint related to multiple care concerns
- Intake: #00099101 - IL-18528-CW, Complaint related to multiple care concerns
- Intake: #00099307 - IL-18620-CW, Complaint related to Housekeeping Services

Intake: #00096069 - Related to falls management. The following intakes were bundled and completed in this inspection: Intake #'s 00093573, #00094933, #00097815, #00098038, all were related to falls.

## Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2023-1703-0003 related to FLTCA, 2021, s. 24 (1) inspected by Katy Harrison (766)

Order #002 from Inspection #2023-1703-0003 related to O. Reg. 246/22, s. 12 (1) 1. ii. inspected by Bernadette Susnik (120)

Order #003 from Inspection #2023-1703-0003 related to O. Reg. 246/22, s. 53 (1) 4. inspected by Helene Desabrais (615)

Order #004 from Inspection #2023-1703-0003 related to FLTCA, 2021, s. 6 (1) (c) inspected by Katy Harrison (766)

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

Resident Care and Support Services
Continence Care
Housekeeping, Laundry and Maintenance Services
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Staffing, Training and Care Standards
Pain Management
Falls Prevention and Management

# 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)**
O. Reg. 246/22, s. 93 (4)

The licensee had not purchased a carpet cleaner/extractor to clean spills and body fluids from various carpeted areas throughout the home and had not provided appropriate cleaning brushes for the tubs.

The licensee purchased a portable carpet cleaner on October 19, 2023 which was delivered 5 days later. The manufacturer specifications included that it was ideal for use in hotels, hospitals, offices and schools. New tub cleaning brushes were delivered to the home on October 31, 2023.

**Sources**: Review of carpet cleaner invoice and interview with Southbridge Clinical Consultant and housekeeping staff. [120]

Date Remedy Implemented: October 25, 2023

## WRITTEN NOTIFICATION: Plan of Care

**NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee failed to ensure that a resident's substitute decision-maker, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the implementation of the resident's plan of care.

**Rational and Summary**

A resident had a change in condition and spent the evening in bed sleeping. In addition, they were not given their medications at 1700 and 2000 hours as it was recorded that they were sleeping.

The resident's condition continued to deteriorate. The following day another PSW started work at 1400

hours and shared that they found the resident sleeping so they put them to bed.

The resident was later found in bed unresponsive. The Charge RN assessed the resident and reported that the resident was not oriented and not alert.

The Charge RN reported that the resident's substitute decision maker had not been notified of the change in the resident's condition.

By the resident's substitute decision maker not being notified of the change in the resident's condition, they did not have the opportunity to participate in the implementation of their plan of care.

**Sources:** Review of the resident's clinical record, interviews with complainant, PSW and RN. [155]

## WRITTEN NOTIFICATION: Plan of Care

**NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

**Rational and Summary**

A resident's plan of care stated their goal was to have their bathing needs met, which included a specified intervention. The resident expressed that the goal had not been met.

Review of the resident's clinical records showed that the resident had gone 14 days without the specified intervention.

**Sources:** Resident's clinical records, interview with resident and ADOC. [155]

## WRITTEN NOTIFICATION: Reporting and Complaints

**NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee failed to ensure they immediately reported an allegation of abuse of a resident to the Director.

**Rational and Summary**

An RN reported to the Executive Director (ED) an alleged incident of physical abuse.

The Executive Director conducted an investigation but did not report the allegation of abuse to the Director.

The home's failure to immediately report the incident to the Director may have delayed follow up by the Ministry of Long-Term Care.

**Sources**: Interview with RN and ED, home's complaint investigation form. [155]

## WRITTEN NOTIFICATION: Doors in a home

**NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 12 (2)

The licensee failed to ensure that there was a written policy that dealt with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

**Rationale and Summary**:

The balcony doors on Huron and Sunset home areas and the courtyard door on the ground floor were left unlocked during the inspection. The outdoor temperature was 9 degrees Celsius, a safety issue for residents if unsupervised. The available policy at the time of inspection was insufficient to determine exactly who would lock and unlock the doors, when and during what outdoor conditions.

**Sources:** Observation, review of Door Surveillance and Secure Outdoor Areas policy OP-04-01-04. [120]

## WRITTEN NOTIFICATION: Availability of Supplies

**NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 48

The licensee failed to ensure that there were wash cloths and towels readily available to meet a resident's personal care needs.

**Rational and Summary:**

A resident rang their call bell two consecutive times. A PSW answered the call bells promptly and the resident told them that they required care.

The PSW had to go to the laundry to obtain wash cloths and towels so that the care could be provided.

As a result of wash cloths and towels not being readily available, the resident waited unnecessarily for care to be provided.

**Sources:** Interviews with resident, PSW and observations of resident and linen cart. [155]

## WRITTEN NOTIFICATION: Menu Planning

**NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 77 (5)

The licensee failed to ensure that the planned menu items for a resident were available at each meal.

**Rational and Summary**

The resident expressed concerns that their planned menu items were not available.

Review of the resident's plan of care stated that they were to have the items at all meals, when requested.

Observations done at breakfast showed that the items were not available to offer to the resident.

The Food Service Manager (FSM) shared that the items had not been ordered.

**Sources:** Interviews with resident, FSM, observations of breakfast, resident clinical records. [155]

## WRITTEN NOTIFICATION: Maintenance services

**NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 96 (2) (i)

The licensee has failed to ensure that procedures were developed and implemented to ensure that the temperature of the hot water serving all bathtubs and showers used by residents was maintained at a temperature of at least 40 degrees Celsius.

**Rationale and Summary**

Hot water temperature logs for the tubs and/or showers which were reviewed for the Huron, Sunset, Maple Heights and Georgian Heights home areas included hot water temperature values between 37 and 39 degrees Celsius between October 1-17, 2023. The log form clearly identified that the minimum hot water temperature range was to be 40 to 49 degrees Celsius. The hot water temperature monitoring procedure dated August 2023 (RFC-01-06-02) identified that the handheld thermometer used to measure the water was to be held in a filled tub until a steady reading was achieved within the range of 40 to 49C, and if so, the resident could proceed to be immersed into the water. This temperature range is unsafe for any bath which must not exceed 40C.

On October 31, 2023, the Southbridge clinical consultant identified that the values recorded by staff for the tub and shower temperatures were of the temperature of the shower or tub bath that was given to residents. Therefore, the actual hot water serving each fixture was not measured.

Failure to ensure that procedures are developed in accordance with s. 96(2)(i) of Regulation 246/22, which only requires that the hot water serving the fixture be a minimum of 40C, may lead to scalding injuries for residents.

**Sources:** Review of water temperature logs and water temperature monitoring procedure RFC-06-01-02, discussion with clinical consultant.

## WRITTEN NOTIFICATION: Maintenance services

**NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.**
Non-compliance with: O. Reg. 246/22, s. 96 (2) (k)

The licensee failed to ensure that procedures were developed and implemented to ensure that the temperature of the water was monitored once per shift in random locations where residents had access to hot water.

**Rationale and Summary**

Some of the night shift hot water temperature values that were recorded by registered nurses (RNs) between September 1-14, and October 4-16, 2023 did not include which resident accessible fixtures were measured. Very few identified the room number or a particular lounge, and others identified only a home area. The temperatures were missing for Sept 1, 2, 4, and 23rd. On September 21st, and

October 5, 2023, the air temperature was recorded as the water temperature. The thermometer that was used by the RNs was identified to be an infrared thermometer (which records surface temperatures) and was faulty when tested. The water temperature log included what action to take when air temperature exceeded 26C, but no direction for staff if water temperatures exceeded 49C.

The home's procedure RC-06-01-02 dated January 2022, was amended in August 2023 to RCF-06-01-02. In doing so, the licensee excluded information with respect to taking hot water temperatures in random locations on each shift, at fixtures that are accessible to residents. The amended procedure did not include any information about areas outside of the tub and shower rooms, how to take temperatures properly, what thermometer to use, how to ensure the thermometers were accurate and for how long to run the water.

**Sources**: Review of water temperature logs and hot water monitoring procedure RC-06-01-02, RFC-06-01-02, interview with Southbridge Clinical Consultant. [120]

## COMPLIANCE ORDER CO #001 Housekeeping

**NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.**
Non-compliance with: O. Reg. 246/22, s. 93 (2) (a) (i)

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

The licensee shall;

1. Revise the cleaning frequencies chart/list and both the housekeeper and evening housekeeper job descriptions to include all areas of the home that are required to be cleaned, including deep cleaning of the floors.
2. Ensure that each space within the home identified on the revised cleaning frequencies chart/list is evaluated for infection risk by the licensee's IPAC lead, ESM and ED based on the "Risk Stratification Matrix to Determine Frequency of Cleaning" (Appendix 21) identified in the document entitled "Best Practices for Environmental Cleaning for Infection Prevention and Control, April 2018". The assessed risk is to be used to establish the frequencies for cleaning each space within the home, including the flooring. The completed assessment shall be shared with the housekeeping staff, and procedures and schedules developed or amended to reflect any changes.
3. Ensure that the housekeeping staffing plan correlates with the amended frequencies chart/list and includes additional time for isolation cleaning and deep cleaning when and where necessary.

4. Ensure that regular formal communication is held between the Environmental Services Manager (ESM) and housekeeping staff related to the housekeeping program and that records are kept of the communications.

5. Develop a process to monitor which spaces within the home are not fully cleaned as per evidence-based practices and the cleaning frequencies chart/list. The process should include documentation of the course of action taken in relation to those spaces within the home that could not be cleaned and who is responsible.

6. Develop or revise the absence management system so that attendance records clearly and accurately reflect who will or has replaced a housekeeper on their assigned shift when they are not able to work.

7. Ensure that any staff member who is directed to perform duties outside of their job description is provided education or training prior to them beginning any newly assigned tasks and duties. A record of the education or training shall be maintained which includes how the education or training was provided, who provided it, when, for how long and who attended.

8. Ensure that all nursing care staff are re-oriented to their duties as per procedure HL-05-01-20 entitled “Blood and Other Body Fluids” and any health and safety procedures related to cleaning body fluids. A record of the re-orientation of care staff shall be maintained which includes how the re-orientation was provided, who provided it, when, for how long and who attended.

9. Ensure that all care staff have direct access to appropriate cleaning supplies to remove and clean body fluids immediately from the floor, carpet, bed mattresses, toilets and other surfaces during their shift when caring for residents.

**Grounds**

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 implemented for cleaning of the home, including floors, carpets, furnishings, contact surfaces and wall surfaces.

**Rationale and Summary**

Several complaints were received in early October 2023 about a shortage of housekeeping staff for a home that has three floors, five resident home areas (with 32 beds each), a service area and a wing with large common areas, offices, and staff only areas.

During the inspection, a housekeeper had just completed cleaning urine from a mattress that had been left to pool by a personal support worker. The inspector and housekeeper removed the mattress cover and observed that the foam inside had already been saturated and was odourous. A family member

complained about overflowing garbage. A resident complained that their room was not routinely cleaned and that at times, only their garbage was removed. The Inspector observed a family member ask a PSW if they could get the floor in a resident's room cleaned as it had feces on it. The PSW did not clean the feces but responded that they called a housekeeper. More than one hour later the floor had not been cleaned. Four out of the five tub rooms had ground in dirt within the textured flooring, creating black patches. A floor cleaning schedule using a floor machine was not available for review to determine who and how often the floors were to be cleaned using a floor machine. All five housekeeping staff reported that when there was no coverage for a missing housekeeper, the remaining housekeepers had to omit cleaning the sinks, toilets, touch point surfaces, carpeting, furnishings in order to pick up the garbage and only spot clean where visibly soiled.

Cleaning procedures and frequencies were not implemented according to housekeeping staff. The licensee had a total of two evening housekeepers (previously identified as janitors) and eight housekeepers from August 20 to Sept. 2, 2023. By September 17, 2023, there were only six housekeepers identified on the cleaning schedule. One employee was added to the schedule temporarily for a total of six days between September 22 and October 12, 2023.

According to the Environmental Services Manager, the usual or required cleaning schedule was to include five housekeepers and one evening housekeeper each day. According to work schedules, four housekeepers were allocated to five home areas 11 days out of 19 days in September and 10 days out of 23 days in October 2023. The Environmental Services Manager who was responsible for allocating housekeepers to the RHAs each month reported that they could not fill all days with five housekeepers because at times, there was no one available to fill the job.

The written job routine and task breakdown (with times) for the housekeepers (7 a.m.-3 p.m. shift) was reviewed dated January 10, 2023, and included 32 resident rooms, 27 washrooms, the floor in the dining room, a lounge, an activity room, nurse's station, balcony or patio, corridor rails, and bath/shower room with washroom. Excluded from the routine was the staff meeting room, clean utility room, soiled utility room, and one office per RHA. The routine was subsequently revised in late October 2023 which additionally excluded the activity room, nurse's station, and balcony or patio.

The written job routine and task breakdown (with times) for each evening housekeeper (11 a.m.-7 p.m. shift), was reviewed dated January 10, 2023 and included ground floor administration area, offices, lobby, conference room, staff lunch room, beauty salon, physiotherapy room, staff locker rooms, both elevators, garbage removal, floor cleaning of corridors and common areas in each RHA, common area washrooms, garbage and soiled linen chute rooms, and all tub/shower room floors. Excluded from the routine was the large activity area, chapel/theater, deep cleaning of the service corridor, laundry room, kitchen, loading/receiving area and servery floors, and a therapy waiting area, washroom and therapy room per floor. The routine was subsequently revised in late October 2023 which included some of the

tasks from the day shift housekeepers (common areas in each RHA), dining room floors, activity rooms, meeting rooms, lounges and common washrooms, garbage disposal and window cleaning.

The reasons provided as to why the procedures and frequencies could not be implemented included the following;

· Housekeepers were required to assist in the laundry room, servery and dining rooms when dietary and laundry staff were absent. The cleaning therefore was not completed for the housekeeper's assigned area. During these times, other housekeepers were required to limit the amount of cleaning in their own RHAs so that they could pick up the garbage and complete spot cleaning in the vacant RHA.

· Absent housekeepers were not always replaced as there were no staff available. For eleven days out of 30 in September and seven days out of 31 in October 2023, there were only four housekeepers scheduled to work in specific home areas. One evening housekeeper or both, and one or both maintenance staff (who were employed as of September 1, 2023, but no longer on the schedule from October 29-November 11, 2023) were often required to fill in. The maintenance staff did not receive any training by an experienced housekeeper to ensure that they cleaned the spaces in accordance with best practices. The workload normally assigned to the evening housekeeper and maintenance staff was reported to have been impacted with no coverage.

· During the last two respiratory outbreaks (which prevailed throughout September 2023), enhanced cleaning and disinfection was difficult due to the staff shortages, and the licensee assigned two new maintenance staff to clean touch point surfaces in common areas.

· The allocated time provided to complete cleaning and disinfection tasks was not in keeping with the number of housekeepers that were on the schedule. Time was not incorporated to deal with personal risk assessments prior to entering resident rooms, to don and doff personal protective equipment, to deep clean rooms after a vacancy or after an outbreak, to speak to residents, conduct additional cleaning for residents who soil their bed surfaces, toilets, flooring and carpeting or when juice and food debris are spread over into resident rooms and corridors that require more than a spot cleaning. The allocated time of eight hours for the day shift housekeeping position, was insufficient. The staff identified that they were routinely unable to complete the cleaning that was required.

According to the Executive Director (ED) and the staffing contingency plan, there were two janitors (evening housekeeper) and three maintenance persons available to assist in some of the duties or to fill in when one or more housekeepers were not available. When documentation was requested to determine who filled in for whom, it was not easy to follow, and various versions of the schedule were provided for the same time period.

The ED and other management staff reported that they struggled with acquiring additional staff, however no job postings for additional housekeepers were noted on their website and only a part time housekeeping position was posted for weekends or rotating weekends on an external website.

Failure to implement cleaning procedures for the home may impact resident and staff health and safety, increase the duration and severity of disease outbreaks, and contribute to an increase in resident and staff complaints.

**Sources**: Review of cleaning procedures (HL-05-01-10A1 to HL-05-01-14 A13), schedules, job routines, frequencies (Appendix 1), time sheets, staffing contingency plan, interview with the Scheduler and Intake Manager, Southbridge Corporate Consultants, Southbridge President of Operations, Executive Director, residents, housekeepers, janitors, maintenance staff, and observation of the general sanitation of the home. [120]

**This order must be complied with by**

November 30, 2023

## COMPLIANCE ORDER CO #002 Housekeeping

**NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.**

Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (ii)

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

The licensee shall:

1. Ensure that all of the dishwashers are functional.
2. Develop and implement a written procedure for staff that clearly identifies how and when the dishwasher in each soiled utility room will be used to clean (not disinfect) non-medical devices. The procedure shall include how the devices will be disinfected once removed from the dishwasher and how often and when non-medical devices need to be discarded.
3. All non-medical devices shall be deep cleaned followed by disinfection, using the dishwasher or a sink, once per week. The IPAC lead shall develop and implement a routine auditing schedule to ensure successful completion of the tasks. The auditing results shall be maintained for review.
4. Once the stainless-steel sinks are installed, a disinfectant dispensing system shall also be installed above the sink which staff will use to dispense the appropriate dilution of disinfectant into the sink.

5. Develop and implement a written procedure for care staff that clearly identifies how the stainless-steel sinks will be used and for what purposes.

6. Revise existing written procedures that identify for care staff how to clean non-medical devices. Include how they will clean and disinfect washbasins, and bedpans while in resident washrooms using supplies that are readily available in the residents' washrooms such as disposable disinfectant wipes.

7. Ensure that non-medical devices are stored by care staff in an area where they will not be contaminated by toileting activities, and in an area that will not impede resident movement around the sink area.

**Grounds**

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 disinfection of devices using at a minimum, a low-level disinfectant in accordance with evidence-based practices.

**Rationale and Summary**

Evidence-based practices for cleaning and disinfection of non-critical medical devices includes but is not limited to the following document entitled "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".

Wash basin, bed pans and/or urinals, which are non-critical medical devices, were observed stored in an unhygienic manner in most resident washrooms, stored on towel bars, on toilet tanks or on the floor. The medical devices were not cleaned or disinfected between use but were just rinsed out and left to air dry. Housekeeping staff reported that if they found the washbasins on bathroom vanities, they emptied the basins and rinsed them out. According to the licensee's device cleaning procedures, PSWs were to obtain a cloth and bottle of disinfection solution from the housekeeping closet and clean the bed pans or wash basins in the resident's washroom. For bed pans, liners were to be used in order to prevent staff from handling overly soiled devices. At the time of inspection, liners were not used by care staff, there were no cloths or disinfectant bottles available in housekeeping closets and the option of equipping resident washrooms with disposable disinfectant wipes was not employed. Discussions were held with Southbridge management staff about the impracticalities and time limitations with their procedures which directed care staff to go and retrieve supplies from a housekeeping closet each time a washbasin or bed pan had to be cleaned in a resident's washroom.

The soiled utility room on each resident home area, which is required to be equipped with a utility sink and/or mechanical washer for staff to use when cleaning and disinfecting devices and other items, was not equipped for staff use. Signs were attached to the dishwashers that they were not to be used until replaced with a different type of machine and the rooms were used for storage purposes, blocking access to the hand sink and dishwasher. The hoppers were sealed off with a plastic bag and there was no utility sink. Therefore, no options were available for staff to deep clean any devices, spot clean large equipment (walkers, wheelchairs), personal aides or to be able to rinse food stains from clothing, wash shoes or other resident items that can't go to laundry. A fully functioning soiled utility room with the appropriate equipment, fixtures, cleaning and disinfection supplies is a requirement under the LTC Home Design Manual 2015, section 7.3.

When the home was originally reviewed in December 2022, prior to licensing, the Southbridge senior management team reported that they had ordered but not received dishwashers which were to be used to clean the devices, specifically wash basins and bed pans. The hopper, which was installed, was an acceptable option as long as it was not used for rinsing of body fluids from linens, disposal of body fluids or the cleaning of devices. During the inspection, although procedures were developed for cleaning and disinfection of medical devices while in resident rooms, the soiled utility room procedure did not include how and when to use the dishwasher or the hopper.

In January 2023, public health nurses who visited the home recommended that the hopper be replaced with a proper utility sink and the washer had not yet been installed. The practice of using the hopper for cleaning the various devices was supported. In March 2023, following a gastroenteritis outbreak, a public health nurse requested that the hopper and dishwasher be discontinued all together (as it did not have a disinfection cycle) and that a machine that is appropriate for the devices be purchased. A two-step cleaning and disinfection process was also recommended for the various devices. The licensee responded stating that they would replace the washing machines with a different type of machine. and educate their care staff in the two-step cleaning and disinfection process.

Failure to develop clear cleaning and disinfection procedures for medical devices in accordance with evidence-based practices and subsequently implementing them may contribute to disease outbreaks or a delay in controlling the duration of outbreaks.

**Sources**: Interview with care staff, registered staff, housekeepers, Grey Bruce Public Health Unit (GBPH) nurses, observations and review of email correspondence from GBPH, review of equipment and device cleaning procedures 10.15 (Bed pans, Basins and Urinals Cleaning), 10.16 (Soiled Utility Rooms). [120]

**This order must be complied with by** December 08, 2023

## COMPLIANCE ORDER CO #003 Reporting and Complaints

**NC #012 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.**
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

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

a) All managers at the home receive education regarding Fixing Long-Term Care Act, 2021, s. 28 (1) reporting certain matters to the Director. The education shall include the communication from the Ministry of Long Term Care, Reporting Requirements for LTC Homes dated Oct 2022 (updated June 2023).

b) A copy of the education provided along with the name and date of the staff that received the education will be kept available in the home.

**Grounds**
The licensee failed to immediately report to the Director allegations of improper care and treatment of two resident's.

**Rational and Summary**

a) A resident's family member complained to the Assistant Director of Care (ADOC) that the resident alleged that a Personal Support Worker (PSW) was disrespectful and treated them in an inappropriate manner.

The ADOC stated they completed an investigation and did not report the allegation of improper treatment of the resident to the Director and the PSW remained working in the resident's home area.

**Sources**: Complainant's email, home's complaint form and investigation, interviews with PSW and ADOC. [615]

b) An RN received a call from a resident's substitute decision maker expressing that they were upset that the resident had not been assessed and they had not been notified of the resident's change in condition. They requested that an investigation be done.

The ADOC completed a complaint investigation, but they did not report the allegation of improper care and treatment to the Director. The Executive Director (ED) shared that allegations of abuse, neglect,

improper care and treatment would be immediately investigated. They then discuss their investigation with the substitute decision maker (SDM) and if they felt the allegation was substantiated and wanted it reported to the Director then they would report it.

The home's failure to immediately report incidents of improper care and treatment to the Director may have delayed follow up by the Ministry of Long-Term Care.

**Sources:** Interview with RN, ADOC, and ED, resident clinical records and home's complaint investigation form. [155]

**This order must be complied with by** November 30, 2023

## 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.