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
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Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: January 24, 2024
Original Report Issue Date: January 4, 2024
Inspection Number: 2023-1377-0007 (A1)
Inspection Type: Critical Incident Follow up
Licensee: Extendicare (Canada) Inc.
Long Term Care Home and City: Extendicare Halton Hills, Georgetown

Amended By Bernadette Susnik (120)	**Inspector who Amended Digital Signature** Bernadette Susnik Digitally signed by Bernadette Susnik Date: 2024.01.29 16:00:27 -05'00'

AMENDED INSPECTION SUMMARY

This report has been amended to extend the compliance due dates for compliance orders #001 and #004.

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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: 2024.01.29 16:00:58 -05'00'

AMENDED INSPECTION SUMMARY

This report has been amended to extend the compliance due dates for compliance orders #001 and #004.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 4, 5, 7, 2023
The inspection occurred offsite on the following date(s): December 12, 13, 14, 18, 20, 2023

The following intake(s) were completed during this follow-up inspection:

- Intakes: #00098204/00098205 related to cleanliness and repair.

The following intakes were completed during this Critical Incident Inspection:

- Intake: #00099931 - Respiratory Outbreak
- Intake: #00100801 - Breakdown of major equipment in the home (Heating systems)

Previously Issued Compliance Order(s)

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

Order **#001** from Inspection #2023-1377-0005 related to FLTCA, 2021, s. 19 (2) (a) [Cleanliness of the home] inspected by Bernadette Susnik (120)

Order **#002** from Inspection #2023-1377-0005 related to FLTCA, 2021, s. 19 (2) (c) [State of repair of the home] inspected by Bernadette Susnik (120)

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: Housekeeping

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (a)
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,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

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 implemented for cleaning of the home.

Rationale and Summary
The Extendicare floor maintenance procedure HL 05-01-13 directed the licensee to review the standard floor cleaning procedures provided in their Appendices, adapting them as necessary to reflect their home's specific needs. The procedure directed the licensee to check with the flooring manufacturer for specific floor care needs and incorporate their directions into the home's procedures. A cleaning frequency of "as needed" for tub and shower rooms was also included in a separate procedure. Neither procedure was implemented or amended to reflect the conditions in the home.

During the inspection, the following observations were made;

- Tub and shower rooms in various home areas had black stains and ground in dirt and traffic patterns in and around shower cabins and tubs. The floors were not cleaned as needed.

- The large sliding glass windows (same height and width as a door) were located in the corridors throughout the home and had a heavy build-up of debris in the tracks on each day of the on-site inspection. Extendicare cleaning frequency for window interiors was as required and weekly. No specific procedure was developed to ensure that the tracks were adequately cleaned.
- Many of the ceiling vents located in common areas were very dusty on each day of the on-site inspection. Extendicare procedure (Appendix 10) for vent cleaning required staff to clean them as required or bi-weekly. The frequency was not adhered to.

Sources: Observations, interview with Extendicare Consultant, Environmental Services Supervisor, Compass District Manager, Executive Director and review of floor care procedures and cleaning frequencies HL 05-01-13, HL 05-01-09, and floor cleaning schedules. [120]

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) (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 procedure IC-02-01-12 (Personal Care Equipment: Cleaning and Disinfecting), which was developed in accordance with several evidence-based practices from Public Health Ontario with respect to the method and frequency of cleaning and disinfecting personal care equipment, it was not home-specific and difficult for staff to follow and therefore not implemented. In addition, the procedure failed to include current direction from section 5.8 of the I*nfection Prevention and Control (IPAC) Standard, September 2023* related to the disposal of human waste.

The majority of residents were provided with plastic wash basins, and some with bed pans, urinals, and kidney basins, all of which required cleaning and disinfection after each use, as identified in the evidence-based practices and procedure IC-02-01-12. Staff were to rinse the basin after use, and if visibly clean, use a disinfectant wipe or apply a liquid disinfectant with a single use cloth and to let the basin air dry. If dirty, they were to take it to the soiled utility room for cleaning and disinfecting. The procedure did not include what steps to take once in the soiled utility room.

For urinals and bed pans, the procedure directed staff to carry the covered human

waste down the corridor to the soiled utility room and dump the contents in the hopper. No alternatives were provided such as the use of disposable liners or how to properly dispose of the waste in the resident's toilet before carrying it to the soiled utility room for cleaning and disinfection as per section 5.8 of the IPAC Standard.

During each day of the on-site inspection, the washbasins specifically were observed with a layer of hard water scale (a white substance) stuck to the bottom of the interior, a sign that water was left sitting in the basin. None of the resident washrooms observed (a minimum of 5 per home area) had any disinfectant supplies readily available to staff to complete cleaning and disinfection of the basins. Care carts and clean utility rooms did not include any disinfectant products. Although one corridor in each home area had disinfectant wipe container holders on the walls next to the floor lift parking niche, many were missing containers, or the containers were empty across a four-day period. Most of the tub and shower rooms, which also had disinfectant wipe container holders, were missing the containers.

Four residents on contact precautions did not have any disinfectant wipes provided along with the personal protective equipment stored in caddies outside of their rooms. The surfaces and equipment in these rooms required additional cleaning and disinfection, which was not completed.

The soiled utility rooms were not equipped with supplies, products, sinks or cleaning equipment for staff to be able to follow the procedures for deep cleaning the personal care equipment or the hoppers after their use. Two soiled utility rooms had expired liquid disinfectant and all, but one had a container of disinfectant wipes which remained sealed for four days. None were equipped with cleaning cloths, a utility sink and only three (out of five) had a dishwasher for deep cleaning the personal care equipment. One dishwasher had a bag of items inside for four days.

Staff for the other two home areas were expected to take soiled equipment out of the home area. All five had a flushing hopper. The procedure did not include how to use the dishwashers.

Four different PSWs revealed that they rinsed the basins after use, and sometimes they would use the hand sanitizer, soap or if available a disposable disinfectant wipe to clean and disinfect the basin.

The IPAC lead last audited staff cleaning and disinfection practices in November 2022 and stated that they were required by their procedure IC=06-01-01 to complete such an audit once per year. The lead had identified issues with staff adherence to the cleaning and disinfection procedures and provided re-orientation to all care staff in December 2022 and to additional new staff in March 2023. No follow-up audits were completed. The lead was unaware of the issues identified during the inspection.

Failure to develop and implement clear home-specific cleaning and disinfection procedures for non-critical medical devices in accordance with evidence-based practices and subsequently implementing them may contribute to the spread of infectious organisms, outbreaks or a delay in controlling the duration of outbreaks.

Sources: Interview IPAC Lead, 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, Extendicare procedures IC-02-01-12 (Personal Care Equipment: Cleaning and Disinfecting), IC-06-01-01 (IPAC Quality Improvement), Cleaning and Disinfection Audit - IC-TA07 form. [120]

WRITTEN NOTIFICATION: Infection prevention and control

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to implement any Standard issued by the Director with respect to infection prevention and control, specifically, under sections 5.3, and 9.1 (e), i of the Infection Prevention and Control (IPAC) Standard, revised September 2023.

Rationale and Summary
Under section 5.3 of the IPAC Standard, the licensee was to ensure that the policies and procedures for the IPAC program included policies and procedures for the implementation of Routine Practices, specifically the use of environmental controls. The licensee's procedures related to routine practices did not include any environmental controls. These controls include but are not limited to the location or placement or storage of residents' personal care equipment (bed pans, wash basins, urinals) as identified under section 9.1 (e) i of the IPAC Standard.

During the inspection, numerous resident washrooms in each of the five resident home areas were observed to have urinals, urine hats, bed pans and wash basins stored either on the floor, toilet tank or, on the vanity. An excessive number of toilet paper rolls (2 to 3) were stored on toilet tank lids. The washrooms were equipped with two small drawers, whether in a private or basic room configuration. No other storage cabinetry, shelving or another storage solution was available. Glove boxes

were observed on vanities, resident night tables, or on top of the soap dispenser cabinets in resident washrooms and on various surfaces in tub and shower rooms. Many resident washrooms were missing glove box holders or had an insufficient number of holders. Showering products such as shampoo and liquid soap were observed on the floor or on plastic shower seat. The shower rooms did not have any or had insufficient shelving in the large shower areas for staff to place products while showering a resident.

Failure to ensure that the environment is arranged or designed to allow for proper storage, and that the environment is maintained to limit the number of surfaces that can become contaminated and allow for proper cleaning and disinfection may impede the process of controlling the spread of infectious organisms.

Sources: Observations, review of the licensees IPAC related policies and procedures, interview with the IPAC lead and Director of Care. [120]

WRITTEN NOTIFICATION: Visitor policy

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 267 (1)
Visitor policy
s. 267 (1) Every licensee of a long-term care home shall establish and implement a written visitor policy which at a minimum,
(a) includes the process for visitor access during non-outbreak situations and during an outbreak of a communicable disease or an outbreak of a disease of public health significance, an epidemic or a pandemic;
(b) includes the process for documenting and keeping a written record of,
(i) the designation of a caregiver; and
(ii) the approval from a parent or legal guardian to permit persons under 16 years of

age to be designated as a caregiver, if applicable;
(c) complies with all applicable laws including any applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act; and
(d) ensures that essential visitors continue to have access to the long-term care home during an outbreak of a communicable disease, an outbreak of a disease of public health significance, an epidemic or a pandemic, subject to any applicable laws.

Rationale and Summary
Extendicare's Visitor Policy was provided by the Executive Director (ED) as the home's visitor's policy when requested. The Extendicare policy was developed as a guidance document for the ED or IPAC lead of the home to use in developing their own specific policy. The policy included tasks and responsibilities to either follow province-specific directives, to ensure that certain processes were in place and to consider certain processes. A statement was also included in the policy that visitors were to have access to the "home's visitor policy". The policy was not developed for the visitor and did not include specific visitor information that would inform them as to the process of gaining access to the home during non-outbreak and outbreak situations and what steps were necessary while visiting with a resident. It also failed to include Information from the document titled Covid-19 Guidance Document for *Long-Term Care Homes in Ontario* (released November 2, 2023, by the Assistant Deputy Minister), and the *Minister's Directive (*August 30, 2022) related to screening, masking, and other visitation directives.

Sources: Review of Extendicare Visitor's Policy (RC-0-01-06), interview with the Director of Care and Executive Director. [120]

WRITTEN NOTIFICATION: Website

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 271 (1) (f)
Website
s. 271 (1) Every licensee of a long-term care home shall ensure that they have a website that is open to the public and includes at a minimum,
(f) the current version of the emergency plans for the home as provided for in section 268;

The licensee failed to ensure that they had a website that included at a minimum the current version of the emergency plans for the home as provided for in section 268.

Rationale and Summary
Although the licensee's website included a link labelled “Emergency Response Plan” on their Quality Initiatives page, the link opened a document titled “Emergency Preparedness and Response Program. A statement at the top of the document included that the program that was posted provided an overview of the licensee's emergency response program only and did not include any of the thirteen emergency plans required under section 268 of Ontario Regulation 246/22.

Sources: Review of the website and correspondence with the Executive Director. [120]

WRITTEN NOTIFICATION: Website

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 271 (1) (g)

Website
s. 271 (1) Every licensee of a long-term care home shall ensure that they have a website that is open to the public and includes at a minimum,
(g) the current version of the visitor policy made under section 267; and

The licensee failed to ensure that they had a website that included at a minimum the current version of the visitor policy made under section 267.

Rationale and Summary
The licensee's website did not have a link to their visitor policy.

Sources: Review of the licensee's website and discussion with the Executive Director. [120]

COMPLIANCE ORDER CO #001 Home to be safe, secure environment

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall complete the following;

1. Amend the Code Grey -Loss of Essential Services procedure and RC 08-01-03 - Preventing Cold Related Illness to include home-specific details about managing

portable space heaters. At a minimum, information should include how to use them, what temperature settings are appropriate, where to place them in resident accessible areas for safety, where they are to be stored when not in use, and what monitoring is necessary (if any) when in use. The amended procedures shall be conveyed to all staff and implemented.
2. Include in existing IPAC outbreak control procedures information as to when to limit or use portable fan or heater equipment (that blows hot air around) during outbreak and non-outbreak situations. The amended procedures shall be conveyed to all care staff and implemented.
3. Remove the bun warmer in the Terra Cotta servery or secure the unit so that it cannot be moved.

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

Rationale and Summary
1. In October 2023, the licensee submitted a critical incident report that two roof top heating units were non-functional, which affected the heat for two resident home areas. Supplemental heating was functional in the form of radiant ceiling heat panels for resident lounges, bedrooms, tubs/shower rooms and washrooms, but not dining rooms, or corridors. Approximately 12 portable heaters were purchased for distribution to the two home areas. During the inspection, two different models of heaters were observed in corridors and a lounge. One model in particular was very hot when touched and was blowing hot air out of a grille that was 62˚C when measured with a probe thermometer. The damage that was caused by the heaters was observed in the corridor outside of two identified resident rooms. The Acrovyn wall protection had become detached from the wall and had transformed it's shape so that it was no longer flat. A sign was posted by the IPAC lead in some of the corridors instructing staff to position the heaters one foot away from the wall so it could blow towards the wall. The use of the heaters at the time of inspection was

not supervised.

The Environmental Services Manager (ESM) and the Executive Director were informed of the concerns during the inspection. Discussion was held about alternative options, to ensure that the heat could be maintained without the risk of burns to residents. The heaters were removed on or about December 12 2023, as per the Environmental Services Manager (ESM).

Neither of the licensee's procedures (Code Grey -Loss of Essential Services or RC 08-01-03 - Preventing Cold Related Illness) included any home-specific details about managing portable space heaters, how to use them, where to place them in resident accessible areas for safety, where they were stored for staff to access, what monitoring was necessary, etc.

2. In October 2023, one home area was declared by public health to be in an outbreak related to COVID-19. According to the IPAC lead, when a portable heater was placed outside of an ill resident's room on an evening in October 2023, the number of ill residents increased by more than 50% in the same corridor over the course of the week. The IPAC lead suspected that a heater that was placed outside of an ill resident's room was responsible for pushing viral particles along the corridor and was acting as a fan. Once removed, no further cases were identified. Public Health Ontario has identified that air flow changes created by a fan are an important factor in transmission of infections, along with inadequate fresh air. The affected home area did not have a functioning air make up unit supplying heated fresh air to the area. The licensee's outbreak control procedures or air-borne or droplet precautions did not include any information for staff about when and how to use portable equipment that blows air into the room during outbreak or non-outbreak situations.

3. The bun or bread warmer in the Terra Cotta servery was not adequately secured. The entire unit almost fell out of the cabinetry it was built into when attempting to

open the drawer door. The unit may cause serious injury if not adequately secured. A dietary staff member was aware of the unit's condition and said it had not been used for years.

Failure to manage the environment for safety risks when certain equipment is used or installed may lead to injury and/or disease transmission.

Sources: Observations, interview with the ESM, Executive Director, IPAC lead and review of critical incident reports submitted by the licensee, Procedure IC-04-01-03 Managing an Outbreak, Contact and Droplet Precautions procedures, Code Grey - Loss of Essential Services procedure and RC 08-01-03 - Preventing Cold Related Illness). [120]

This order must be complied with by April 15, 2024

COMPLIANCE ORDER CO #002 Communication and response system

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 20 (e)
Communication and response system
s. 20 (e) is available in every area accessible by residents;

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

The licensee shall complete the following;

1. The license shall install a call station in each balcony and courtyard area accessible to residents. The call stations shall be conveniently located near the door on the outside. The single doorbell style buttons shall be removed where previously

installed.
2. Each call station shall be connected to the display board system that has been installed in the home area closest to that call station. (i.e., call station located in the courtyard near Terra Cotta shall be displayed on the display board system in the Terra Cotta home area).
3. The location of the call station shall be clearly displayed on the display board until it is cancelled at the point of activation.

Grounds
The licensee failed to ensure that the home was equipped with a resident-staff communication and response system that was available in every area accessible by residents.

Rationale and Summary
None of the enclosed outdoor spaces, such as balconies, patios, and courtyards accessible by residents were equipped with a call station that was connected to the staff-resident communication and response system. In some outdoor spaces only, a doorbell style push button was installed, which sounded at the nurse's station closest to the outdoor space. One was tested in the Belfountain home area, and it sounded at the nurse's station, but did not sound in the rest of the home area as it was not connected to a scrolling display board that was installed. The display board was being used to display calls from call stations located in the home and the boards also emitted a sound that alerted staff to an active call.

Failure to provide the appropriate call stations in the outdoor spaces prevents residents from alerting staff as to their location and the need for assistance and prevents staff from ascertaining the exact time and location that assistance is required.

Sources: Observation and test of the system (push buttons), interview with the Environmental Services Manager. [120]

This order must be complied with by April 15, 2024

COMPLIANCE ORDER CO #003 Food production

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 78 (7) (c)
Food production
s. 78 (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(c) a cleaning schedule for the food production, servery and dishwashing areas. O. Reg. 246/22, s. 78 (7).

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

The licensee shall complete the following;

1. Outline the equipment, surfaces and areas that must be cleaned daily, weekly, monthly, semi-annually, or annually in a detailed cleaning schedule and assign to designated staff as per Extendicare policy # NC-08-01-05. Ensure that all of the surfaces and equipment in the kitchen, serveries and dining rooms are included on the cleaning schedule and that the cleaning schedule is implemented.
2. Review the cleaning schedule with all staff who are responsible for cleaning the kitchen, serveries, and dining rooms prior to implementation to ensure that all staff understand their cleaning roles and responsibilities. Document who received the orientation and on what date and keep a record of the orientation in the home.
3. Allocate cleaning hours to complete the necessary daily, weekly, monthly, semi-annual, or annual cleaning of the five dining rooms, kitchen and five serveries, and associated equipment, surfaces, and furnishings.
4. The FSM or designate shall complete monthly sanitation audits of the five dining

rooms and five serveries and a weekly kitchen sanitation audit. The audits shall be documented and include what surfaces, equipment and furnishings were reviewed along with any findings, and what actions were taken.

Grounds
The licensee failed to ensure that the home had and that the staff of the home complied with a cleaning schedule for the food production, servery and dishwashing areas.

Rationale and Summary
1. The licensee's cleaning schedule for the kitchen did not include the walk-in coolers, walk-in freezer, any of the wire rack shelving or portable wire carts, walls, ceilings, or cleaning of the floor. Appendix 3 of the licensee's Nutrition Care Manual was not incorporated to ensure all areas were captured for cleaning. The provided schedule included a daily cleaning routine, but no weekly or monthly cleaning routines as per procedure NC-08-01-05 (Cleaning Schedule). Where dietary staff were not able to clean areas such as ceilings or areas that were hard to reach (i.e., behind he stoves), no schedules were provided to indicate who the alternative cleaners would be and the dates that they were scheduled to complete the cleaning.

The following observations of the kitchen were made on December 5, 2023:

- The walk-in coolers both smelled musty and had visible mould on the wall surfaces (and plastic wall bumpers) and on the wire rack shelving. The floors were visibly soiled under the wire rack shelving and around the permitter of the room. The FSM was not aware whether any of the coolers had been deep cleaned within the last six months.
- Wire rack shelving and portable wire rack utility carts provided were heavily rusted.
- Dust and visible food splatter noted on the ceiling, exhaust grilles, and on the

radiant heat ceiling panels.

- The walls around the cooking equipment and some of the cooking equipment were coated in grease.
- Walls in and around the dish machine were coated in scale and other visible matter.
- The large steamer had a heavy amount of water scale inside and the trim and edges had visible matter.
- Some of the stainless-steel fridge exterior surfaces had a heavy accumulation of visible matter.
- The flooring throughout the kitchen was heavily soiled, with excessive accumulations of grease and old food matter underneath fixed tables and behind and underneath the cooking stoves and steamer.

According to the various dietary staff, routine deep cleaning had not occurred for many months and day to day cleaning tasks were not always completed by all staff. The Food Services Manager (FSM) identified that they did not document any of the sanitation audits they completed since their date of hire in July 2023. The flooring (path of travel only) was last deep cleaned on August 9, 2023, according to floor cleaning records.

2. The licensee's cleaning schedule for the serveries did not include cleaning of the cabinetry (both inside and out), walls, floors, ceilings, garbage containers, or dirty dish carts. The frequency of some of the surfaces or fixtures in the provided Dietary Aide Cleaning Checklist did not coincide with Extendicare Appendix 2 identified as a servery cleaning schedule.

The flooring in all five serveries was dark with ground-in soiling on December 4, 2023. When the Terra Cotta and Glen Williams servery floors were cleaned with a floor machine the following day, there was a notable difference. Floor cleaning records between August and December 4, 2023, did not include the serveries.

The Terra Cotta and Glen Williams serveries had visible food matter on the walls, the door separating the two serveries and on cabinetry. The tiled walls in and around the hand sink, beverage sinks, cabinetry and garbage container had visible dried out food matter on them. The hand sinks had heavy amounts of scale on the taps and the sinks were visibly stained. The beverage sinks and counter areas were stained with tea and/or coffee. The cabinet surfaces had visible drip marks, tea/coffee stains and dried out food matter. The ceilings and vents were dusty. A heavy amount of crumbs were under the toaster in the Terra Cotta home area. The dirty dish carts parked in the dining room outside of the serveries had built-in depressions or inserts which were full of accumulated or caked on scale or other debris. Table bases and staff meal assistance stools in some of the dining rooms were visibly splattered and the walls in the dining rooms were dirty dish carts are normally parked were visibly soiled with food matter in all dining rooms.

Sources: Observations, interview with dietary staff, the ESM, FSM, Compass District Manager and Executive Director. (120)

This order must be complied with by February 29, 2024

COMPLIANCE ORDER CO #004 Maintenance services

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 96 (1) (b)
Maintenance services
s. 96 (1) As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance.

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

The licensee shall complete the following:

1. Develop and implement a procedure that includes but is not limited to how surfaces, fixtures and equipment in the home will be kept free of hard water scale, by whom and how often.
2. Thoroughly clean the hard water scale from the equipment and surfaces identified in the grounds below and other surfaces and equipment that have not been identified by the inspector.
3. Develop and implement a procedure that includes but is not limited to how the mini-split units in the home will be cleaned and maintained, by whom and how often and that it includes direction from the manufacturer's user manual where necessary.
4. Thoroughly have the split-mini systems in the kitchen and dishwash areas identified in the grounds below professionally cleaned to remove the dust and black substance resembling mould.
5. Provide a completed maintenance audit for the tub rooms, shower rooms, kitchen, serveries, laundry, and utility rooms (clean and soiled). The audit shall include the condition of all walls, floors, ceilings, windows, doors, fixed equipment, furnishings, plumbing fixtures, and light fixtures. The audit shall include a timeline for repair or replacement where any of the above surfaces, equipment and furnishings were not in good condition.
6. Submit a plan that describes when the cabinetry in the tub and shower rooms and the flooring material in the laundry, Glen Williams shower area, Ballinafad tub room and Terra Cotta shower area will be replaced or repaired and by whom.

Grounds

As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, the licensee failed to ensure that there were schedules and procedures in place for routine, preventive and remedial maintenance.

Rationale and Summary

1. The licensee did not develop a procedure to manage the removal of the extensive amount of hard water scale in the home. The licensee had a water softener that softened only the hot water serving all fixtures. Therefore, the calcium and magnesium deposits were observed wherever the cold-water fixtures were used.

All shower rooms and tub rooms had a heavy amount of scale on the walls behind the tubs and shower cabinets, on the bathtub chair lifts, shower cabinet and shower cabinet chair, on the plumbing fixtures, disinfectant dispensing units and on the floor around the tub and shower cabinet. The main kitchen had accumulated scale on the surfaces of the three-compartment sink and in the steamer. The hand wash sinks in each clean utility and soiled utility room had accumulated scale on the handles and surfaces of the sink. The majority of the washbasins used for resident hygiene had white scale build-up on the bottom of the interior of the basins.

The Food Services Manager (FSM), housekeepers and dietary staff reported that they had not used de-scaling products to remove the build-up of scale on any surfaces. Extendicare procedure MN-4225 (De-liming of the steam cooker) required staff to de-lime the steam cooker on a quarterly basis. A staff member who used the steamer regularly in the kitchen reported that they were not aware of any de-liming procedure and had never de-limed the steamer.

2. The licensee did not develop a procedure to ensure that the mini-split air conditioning units in the home were cleaned as per manufacturer's instructions (every two weeks when in use). The licensee's procedure that was developed (MN

2405) required the units to be checked monthly and were not fully reflective of the manufacturer's requirements. Five units were observed in the kitchen and all five were heavily coated in dust and a black substance resembling mould. The mould appeared on the directional louvres on the air outlet side and on interior components. The Environmental Services Manager (ESM), who started as a maintenance person in April 2023, was not aware of any routine cleaning processes conducted on the units.

3. The licensee's preventative maintenance program included the completion of routine audits of the home by both Extendicare and Compass Canada staff. The audits completed by Compass Canada staff did not identify surfaces, equipment, or furnishings in poor condition in the tub, shower and servery areas. Their remedial program which included some form of response, whether a repair or replacement, was not fully implemented. The following are disrepair issues that were identified during this inspection and during an inspection in July 2023 and remain outstanding;

The lower laminated cabinetry (where provided) in most of the bathing rooms had peeled laminate along the bottom edge.

Split or cracked flooring was observed in the laundry room (in front of the washing machines), Glen Williams shower area along with an unsafe raised drainpipe (with a sign on the wall stating the shower was out of service), Ballinafad tub room near the tub, and Terra cotta shower room (around the drain in the shower area). Water had penetrated into and under all of the flooring material.

Sources: Observations, interview with the ESM, Executive Director, FSM, dietary staff, housekeeping staff, review of maintenance and cleaning audits, job descriptions and Extendicare policies and procedures. [120]

This order must be complied with by April 15, 2024

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

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.