

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

London District

130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Public Report

Report Issue Date: December 16, 2024**Inspection Number:** 2024-1061-0006**Inspection Type:**

Critical Incident

Licensee: Rykka Care Centres LP**Long Term Care Home and City:** Banwell Gardens Care Centre, Windsor

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): December 5, 6, 2024

The following intake(s) were inspected:

- Intake: #00131490 - 2263-000065-24 related to Infection Prevention and Control.

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

Infection Prevention and Control

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.

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NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: O. Reg. 246/22, s. 272

CMOH and MOH

s. 272. Every licensee of a long-term care home shall ensure that all 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 are followed in the home.

The licensee failed to ensure that all hand sanitizer product in the home was not expired as per applicable directives issued by the Chief Medical Officer of Health or a medical officer of health .

Summary and Rationale:

During a walkthrough of the home, many expired hand sanitizer products were observed. As per a directive on page 24 of 'Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings' issued by the Ministry of Health, all hand sanitizer available in the home must have not been expired.

On the next walkthrough completed, it was noted that all expired hand sanitizers were removed and replaced with new product within expiry date.

In an interview completed with IPAC Lead, it was established that the home did not follow the aforementioned directive by having made expired hand sanitizer product available in the home. The Administrator acknowledged the products in question were expired and immediately proceeded to replace them with new ones.

There was risk of the spread of infection when the home allowed expired hand sanitizer products to be have been made available to staff and residents. However, this risk was promptly mitigated when the home replaced the expired product with

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new hand sanitizers.

Sources: observations, interviews, and 'Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings.'

Date Remedy Implemented: December 6, 2024