Ontario

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

Inspection Report under the
Fixing Long-Term Care Act, 2021

London Service Area Office
130 Dufferin Ave, 4th Floor
London ON N6A 5R2
Telephone: 1-800-663-3775
LondonSAO.moh@ontario.ca

Original Public Report

Report Issue Date May 13, 2022
Inspection Number 2022_1487_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Blue Water Rest Home
37792 Zurich-Hensall Rd RR #3 Zurich

Long-Term Care Home and City
Blue Water Rest Home
Zurich

Lead Inspector
Loma Puckerin (705241)

Additional Inspector(s)
Stephanie Morrison (721442)

Inspector Digital Signature
Loma S Puckerin
2022.05.13 14:36:48
-04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): April 25, 26, 27 and 28, 2022.

The following intake(s) were inspected:

- Intake #000127-22 related to Falls Prevention and Management

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Medication Management

INSPECTION RESULTS

During the course of this inspection, the inspector(s) made relevant observations, reviewed records and conducted interviews, as applicable.

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. 138 (1) (a) (ii)

The licensee has failed to ensure that drugs were stored in a medication cart that was secure and locked.

Rational and Summary
On a specific date, a medication cart was observed unlocked and unattended by the registered staff, there were no residents in proximity of the cart. Registered staff returned to the medication cart and locked it. The auto lock on the cart was fixed by the pharmacy and the DOC reminded the registered staff to ensure the cart was locked before leaving it.

Date Remedy Implemented: April 28, 2022 [705241]

WRITTEN NOTIFICATION [INFECTION PREVENTION AND CONTROL PROGRAM]

NC#002 Written Notification pursuant to FLTCA, 2021, s. 154 (1)1

Non-compliance with: O. Reg. 246/22 s.102 (2) (b)

The licensee has failed to ensure all staff participated in the implementation of the Infection Prevention and Control Program (IPAC) in accordance with IPAC Standard for Long-Term Care Homes and with home's Hand Hygiene (HH) policy related to staff not performing HH before and after interactions within the residents' environment. Also, the licensee has failed to ensure the proper use of Personal Protective Equipment (PPE), including appropriate selection, application, removal, and disposal was followed during surveillance testing with a potential droplet transmission of infection.

O. Reg. 246/22, s.102 (2)(b) requires the licensee to implement any standard or protocol issued by the Director with respect to infection prevention and control.

Rational and Summary
A) Personal Support Worker (PSW) #103 was observed not performing hand hygiene after removing the residents' food aprons, clearing residents' utensils, assisting with the feeding of a resident and removing a resident from the dining area. During these interactions with multiple residents, the Inspectors noted that the staff member did not perform hand hygiene.

On another occasion, the same staff member was observed in the dining room assisting residents with their meals and clearing the resident's utensils. Hand hygiene was not performed by the staff member before and after resident interactions. [705241]

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

London Service Area Office
130 Dufferin Ave, 4th Floor
London ON N6A 5R2
Telephone: 1-800-663-3775
LondonSAO.moh@ontario.ca

B) Section 9.1 of the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, April 2022, issued by the Director, required the proper use of PPE and the implementation of evidenced based practices related to potential droplet transmission.

Specifically, a screener had not complied with the IPAC Standard by failing to wear eye protection during a rapid antigen surveillance test, and by improperly doffing an isolation gown between surveillance tests. The IPAC Standard specified that eye protection was required during a procedure or activity which was likely to generate splashes or spays of secretions. Director of Care (DOC) #100 agreed that a rapid antigen test would require eye protection because of the potential to splash secretions. The IPAC Standard stated that used gowns were to be removed into the appropriate receptable and were not to have been re-used for later.

Screener #105 was observed completing a surveillance rapid antigen test without wearing eye protection and had stored their isolation gown on the table between tests for repeat use. Screeners #105 and #106 stated they were not expected to wear eye protection during rapid antigen tests. Both staff members confirmed they used one isolation gown per shift, which they stored between surveillance tests rather than immediately discarding on removal. [721442]

Failing to follow the IPAC Standard issued by the Director, placed residents and staff at risk of a potential spread of healthcare associated infections, including COVID-19.

Sources: Observations; the home's Hand Hygiene Policy # IPCL_1_1A updated November 2021; the IPAC Standard for Long Term Care Homes (April 2022); interviews with the DOC, IPAC Lead #100 and other staff.

[705241]