

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

London District

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

Public Report

Report Issue Date: March 21, 2025

Inspection Number: 2025-1598-0001

Inspection Type:Critical Incident

Licensee: Corporation of the County of Elgin

Long Term Care Home and City: Bobier Villa, Dutton

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 19, 20, 21, 2025

The following intake(s) were inspected:

• Intake: #00136843 - M603-000001-25 - related to Infection Management and Control

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

Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Post Outbreak Debrief

NC #001 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



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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).

IPAC Standard 4.3 issued by Director states "the licensee shall ensure that following the resolution of an outbreak, the OMT and the interdisciplinary IPAC team conduct a debrief session to assess IPAC practices that were effective and ineffective in the management of the outbreak. A summary of findings shall be created that makes recommendations to the licensee for improvements to outbreak management practices." The licensee failed to abide by a standard issued by the Director with respect to infection prevention and control when a summary of findings with recommendations was not completed after an outbreak.

Sources: IPAC Standard 4.3, interview.