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

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Public Report

Report Issue Date: December 16, 2024
Inspection Number: 2024-1403-0005
Inspection Type: Critical Incident
Licensee: Iris L.P., by its general partners, Iris GP Inc. and AgeCare Iris Management Ltd.
Long Term Care Home and City: AgeCare London, London

INSPECTION SUMMARY

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

The following intake(s) were inspected:

- Intake: #00129993 - CI 2919-000048-24 COVID Outbreak.

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.

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 has failed to 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.

Specifically, the Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings issued by the Ministry of Health Effective: April 2024 states:
3.1 IPAC Measures.
Alcohol-based hand rubs (ABHR) are the first choice for hand hygiene when hands are not visibly soiled and must not be expired.

Rationale and Summary
During an Infection Prevention and Control (IPAC) inspection, several ABHRs on the walls in resident rooms were observed to have outdated expiry dates.

The Director of Care (DOC) acknowledged that this did not meet the expectations of the home and that it would be addressed immediately.

During a later observation that same day, all ABHR had current expiry dates. A housekeeping staff confirmed that 9 of the ABHRs had been expired and were changed to new ones that were not expired.

The use of expired products in the home increased the risk of infectious disease transmission to the residents.

Sources: Observations and interviews.

Date Remedy Implemented: December 6, 2024

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #002 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 ensure that all staff participated in the implementation of the Infection Prevention and Control Program (IPAC) in accordance with the IPAC Standard for Long-Term Care Homes.

Rationale and Summary

The IPAC Standard for Long-Term Care Homes (LTCHs) indicated under section 9.1 (b) Routine practice shall include hand hygiene, including but not limited to at the four moments of hand hygiene and section 10.2 (c) The hand hygiene program for residents shall include assistance to residents to perform hand hygiene before meals and snacks.

A staff member was observed providing refreshments to residents in their rooms.

During this observation, approximately 10 residents were provided a refreshment and from approximately 7 of those rooms, the staff member removed soiled dishes from the room. Only one observation of hand hygiene was completed by the staff member when exiting a resident room and no observations of assisting residents or offering assistance to residents to perform hand hygiene before their refreshment was noted.

The IPAC lead confirmed the home's expectation was that all residents are offered assistance with hand hygiene before all meals and snacks. The IPAC lead also confirmed that staff were expected to complete hand hygiene when exiting a resident room and before entering the next resident room when serving refreshments.

Failing to perform hand hygiene and provide support to residents to perform hand hygiene appropriately before snacks may increase the risk of infection transmission in the home.

Sources: Observations and interviews.