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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: August 1, 2024
Inspection Number: 2024-1288-0002
Inspection Type: Critical Incident
Licensee: Hellenic Care for Seniors (Toronto) Inc.
Long Term Care Home and City: Hellenic Care for Seniors (Toronto), Toronto

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: July 30, 31, 2024.

The following intakes were inspected:

- Intakes: #00115229 & 00122039 - Critical Incident (CI)# 2798-000002-24 & 2798-000003-24 - related to disease outbreaks in the home

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

Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

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
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 a Personal Support Worker (PSW) and an Registered Practical Nurse (RPN) adhered to the additional precautions related to personal protective equipment (PPE) selection and removal.

The RPN and PSW did not adhere to the measures in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard). Specifically, they did not apply the appropriate selection and removal of PPE which was required by Additional Requirement 9.1 under the IPAC Standard.

Rationale and Summary
(i) A resident was in isolation and required additional precautions when entering their room according to the signage outside their room. A PSW had entered the resident's room and had close contact with the resident. The PSW did not wear additional PPE when they entered their room and interacted with the resident. The Manager of Infection Prevention and Control (IPAC) indicated the PSW should have worn additional PPE given their proximity of the resident.

(ii) Another resident was on isolation and required additional precautions when entering their room according to the signage outside their room. An RPN was seen interacting with the resident in close proximity and did not wear eye protection. In addition, the RPN did not doff their surgical mask when they exited the resident's

room. The Manager of IPAC acknowledged that the RPN should have worn the eye protection and doffed their surgical mask and applied a new one when they exited the resident's room.

Failure to adhere to IPAC measures may result in further spread of infectious diseases in the home.

Sources: Observations in the home; Line list of residents on additional precautions; Interview with a PSW, an RPN and the Manager of IPAC.