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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Original Public Report

Report Issue Date: February 13, 2024	
Inspection Number: 2024-1565-0002	
Inspection Type: Other	
Licensee: The Corporation of the County of Lanark	
Long Term Care Home and City: Lanark Lodge, Perth	
Lead Inspector Karen Buness (720483)	**Inspector Digital Signature** Karen Lynne Buness Digitally signed by Karen Lynne Buness Date: 2024.03.04 13:02:16 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 23, 24, 30, 31 and February 1, 2024

The following intake(s) were inspected:

- Intake: #00107250 - Infection prevention and control

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

Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control

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 implement any standard or protocol issued by the Director with respect to infection prevention and control (IPAC), related to the use of personal protective equipment, environmental controls and additional precautions and as is required by Additional Requirement 9.1 under the IPAC Standard.

Rationale and Summary (A)

On two separate occasions, while conducting an observation of rooms on special precautions in a resident unit, inspector noted a white laundry bag hanging off the same hook as the Personal Protective Equipment (PPE) caddy on the door of a resident room. The white laundry bag containing soiled laundry was lying against the clean PPE caddy.

A Personal Support Worker (PSW) stated the white laundry bags inspector observed hanging on the doors are used for the resident's soiled laundry so it can be separated prior to it being laundered. When interviewed the Infection Prevention and Control (IPAC) Lead stated the white laundry bags are hung on the PPE caddy

to make it more accessible to the staff but it is not to be used to hold soiled laundry.

The licensee's Safe Handling of Soiled Linens policy and guidelines states soiled linen must never come in contact with clean linen and special linen handling for residents on additional and routine precautions is not required.

Failure to follow infection prevention and control environmental controls increased the risk of disease transmission among residents and staff.

Sources: Inspector observations, Safe Handling of Soiled Linens Policy, Guidelines-Safe Handling of Soiled Linen Appendix, interview with the IPAC Lead a RN and a PSW.

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Rationale and Summary (B)

On a specific date and time, the inspector observed a PSW sitting in a resident unit with their N95 respirator down hanging around their neck. It was noted at that time a resident was sitting within close proximity to the staff member.

At the time of the Inspector's observation, the unit was in a respiratory outbreak. Outbreak update information provided to staff directed staff to wear an N95 respirator when on affected outbreak units

When interviewed the PSW stated staff are required to wear an N95 respirator at all times when on the unit and confirmed they had their mask down around their neck when inspector entered the unit earlier that morning.
The IPAC Lead confirmed that staff are expected to wear an N95 respirator on the unit.

Failure to follow personal protective equipment guidelines increased the risk of disease transmission among residents and staff.

Sources: Inspector observations, licensee communication with staff, and interviews with the IPAC Lead and a PSW.

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Rationale and Summary (C)

On a specific date and time inspector observed Personal Protective Equipment (PPE) hanging on the door of a resident room but no special precautions signage was posted to indicate special precautions. The following day the inspector again observed the room with a PPE caddy but no signage to indicate special precautions was posted.

Inspector reviewed the white board in the communication room on the unit which indicated the resident in the room was on Contact Precautions. When asked, a Registered Nurse (RN) confirmed this information to be correct.

When interviewed, the IPAC lead confirmed this was an error, signage should be on all doors of residents requiring special precautions.

Failure to follow infection prevention and control additional precautions increased the risk of disease transmission between residents and staff.

Sources: Inspector observations, interviews with the IPAC Lead and registered staff.

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