Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under *the Long-Term Care Homes Act, 2007*

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 02, 2022	2022_988522_0001 (A1)	014837-21, 017351-21, 018146-21, 018548-21, 020059-21	Critical Incident System

Licensee/Titulaire de permis

St. Joseph's Health Care, London
268 Grosvenor Street P.O. Box 5777 London ON N6A 4V2

Long-Term Care Home/Foyer de soins de longue durée

Mount Hope Centre for Long Term Care
21 Grosvenor Street P.O. Box 5777 London ON N6A 1Y6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

Amended by JULIE LAMPMAN (522) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 6, 7, 10, 11, 12, 13, 14, 21, 24, and 25, 2022, onsite and January 17, 18, 19, 20, and 26, 2022, offsite.

Tatiana Pyper Inspector #691945 was a secondary inspector during this inspection.

This inspection was completed concurrently with Complaint inspection #2022_988522_0002.

The following Critical Incident System (CIS) intakes were inspected during this inspection:

CIS #C596-000044-21/Log #018548-21 related to falls prevention;

CIS #C596-000043-21/Log #018146-21 related to falls prevention;

CIS #C596-000039-21/ Log #014837-21 related to falls prevention;

CIS #C596-000045-21/ Log #020059-21 related to falls prevention;

CIS #C596-000041-21/Log #017351-21 regarding a hypoglycemic event.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, Assistant Directors of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Personal Care Providers, Resident Support Aides, Dietary Aides, a Recreation Aide, Housekeepers, a Spiritual Care Worker, a Personal Support Worker student, St. Joseph's Health Care Infection Safety Coordinator, Coordinator of Food and Nutrition Services, Screeners, Middlesex-London Health Unit Manager - COVID Program - Outbreak and Facilities Team, Middlesex-London Health Unit Inspector - Infectious Disease Team, a Plumber, a Stationary Engineer, the

Director of Facilities, a Building Equipment Operator, COVID Testers, a private caregiver, London Fire Department Fire Prevention Inspector/Investigator, a family member and residents.

The inspector(s) also observed infection prevention and control (IPAC) practices in the home, resident care, staff to resident interactions, took temperatures in the home, reviewed resident clinical records, staff training records, the home's IPAC audits, and policies and procedures relevant to this inspection.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Infection Prevention and Control
Medication

During the course of the original inspection, Non-Compliances were issued.

- **6 WN(s)**
- **3 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.) Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure the home was a safe and secure environment for its residents.

A) Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, dated December 24, 2021, states:

"Homes must ensure that all staff comply with universal masking at all times, even when they are not delivering direct patient care. Masks must not be removed when staff are interacting with residents and/or in designated resident areas."

“Appropriate eye protection (e.g., goggles or face shield) is required for all staff when providing care to residents with suspect/confirmed COVID-19 and in the provision of direct care within 2 metres of residents in an outbreak area.”

"Homes must ensure that physical distancing (a minimum of 2 metres or 6 feet) is practiced by all individuals at all times, except for the purposes of providing direct care to a resident(s)."

“Homes are required to follow COVID-19 Directive #5 for Hospitals within the meaning of the Public Hospitals Act and Long-Term Care Homes within the meaning of the Long-Term Care Homes Act, 2007, dated December 20, 2021, with respect to Personal Protective Equipment (PPE). LTC staff must wear PPE as required by Directive #5. Required precautions for all health care workers providing direct care to or interacting with a suspected, probable, or confirmed case of COVID-19 are a fit tested, seal checked N95 respirator (or approved equivalent), eye protection (goggles or face shield), gown and gloves."

i) On a specific date, Inspectors #522 and #691945 observed a staff member seated eating in a common area near the entrance to the home. A resident and visitor were seated approximately six feet from the staff member. The home was in a COVID-19 outbreak at the time.

In an interview, the Executive Director (ED) stated the common area was not a designated eating area for staff, and staff should not be unmasked in an area with residents.

ii) On a specific date, Inspector #691945 observed a visitor walk into the home without a mask and attempted to don a mask from the donning station near the entrance.

During that time, three staff members attempted to exit the home. The staff members, who were masked, had to walk near the donning station in order to enter the code into the keypad to exit the home. The staff members were unable to practice physical distancing due to the proximity of the keypad to the donning station.

In an interview, the Middlesex-London Health Unit (MLHU) Manager - COVID Program - Outbreak and Facilities Team stated people exiting the home should

not come in contact with another person who was entering the home without a mask.

iii) On a specific date, Inspector #705243 observed staff #103 exiting resident #005's room. There was additional precaution signage beside the resident's door that stated that an N95 mask with a full-face visor was required. The staff member was observed wearing a face mask with an attached face shield, a gown, and gloves. They were not wearing an N95 mask.

Review of resident #005's clinical records showed the resident was on respiratory isolation and remained on isolation at the time of the observation.

iv) On a specific date, Resident Support Aide (RSA) #151 entered an elevator with Inspectors #522 and #691945 and went to a home area which was in outbreak. RSA #151 was wearing a surgical mask and no eye protection. RSA #151 stated there was no eye protection available when they entered the home.

RSA #151 was later observed in the hallway donning full personal protective equipment (PPE) to deliver snacks to resident rooms. RSA #151 was not wearing an N95 mask.

Staff not wearing appropriate PPE and practicing social distancing put residents at risk for COVID-19 infection.

B) During the infection prevention and control (IPAC) tour of the home, multiple observations were made of staff improperly donning and doffing their PPE, performing improper hand hygiene, wearing their mask improperly, and not using the appropriate mask.

Review of COVID-19 Directive #3 for Long-Term Care Homes under the Long-Term Care Homes Act, 2007, noted homes must "conduct regular IPAC self-audits, at minimum every two weeks when the home is not in an outbreak and at minimum once a week when the home is in an outbreak."

Review of the COVID-19 Guidance Document for Long-Term Care Homes in Ontario stated, at a minimum, homes must include in their self-audit the Public Health Ontario (PHO) COVID-19: Self-Assessment Audit Tool for Long-Term Care Homes and Retirement Homes dated December 23, 2021, which required a tour of the facility.

Review of the home's IPAC Outbreak Audit tool updated December 6, 2021, noted during an active outbreak five staff were to be audited in 24 hours, for IPAC compliance. The audit included: hand hygiene, PPE, environmental cleaning and physical distancing.

Review of the home's IPAC Audits noted a specific home area went into a COVID-19 outbreak on December 25, 2021.

In an interview, ADOC #127 stated they were the IPAC lead for the home. ADOC #127 stated the home had created an IPAC audit tool for when they were in outbreak.

ADOC #127 stated IPAC audits were only completed for outbreak areas and not the entire home after they went into outbreak on December 25, 2021. ADOC #127 stated they managed the best they could, and wanted to focus on outbreak areas.

ADOC #127 stated they were aware that IPAC audits were to be completed weekly and that at a minimum they should have used the PHO COVID-19: Self-Assessment Audit Tool for Long-Term Care Homes and Retirement Homes, which required an audit of the whole facility.

Sources:
IPAC observations of the home, review resident #005's clinical record, Directive #3 for Long-Term Care Homes under the Long- Term Care Homes Act, 2007, dated December 24, 2021, COVID-19 Directive #5 for Hospitals within the meaning of the Public Hospitals Act and Long-Term Care Homes within the meaning of the Long-Term Care Homes Act, 2007, COVID-19 Guidance Document for Long-Term Care Homes in Ontario, PHO COVID-19 Self-Assessment Audit Tool for Long-Term Care Homes and Retirement Homes, the home's IPAC Outbreak Audits and interviews with RSA #151, Staff #103, ADOC #127, MLHU Manager - COVID Program - Outbreak and Facilities Team, the ED and other staff. [s. 5.]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff received retraining in infection prevention and control (IPAC).

Ontario Regulation 79/10 s. 219 (1) requires annual training in relation to infection prevention and control.

During the IPAC tour of the home, Inspectors #522 and #691945 observed on multiple occasions staff don and doff their PPE improperly, staff did not complete proper hand hygiene, staff wore their mask improperly, or did not use the appropriate mask.

Review of St. Joseph's Health Care (SJHC) L003- Leader Certification Compliance Report noted the following IPAC staff training for 2021:

Infection Control Core Competency: Additional Precautions e-Learning Annual Certification 222/302 (72%) staff completed;
Infection Control Core Competency: Hand Hygiene e-Learning Annual Certification 201/323 (62.2 %) staff completed;
Infection Control Core Competency: Routine Practices e-Learning Annual Certification 172/302 (56.9%) staff completed;
Influenza Prevention e-Learning Certification 245 /323 (75.8%) staff completed.

In an interview, the Director of Care (DOC) stated IPAC training was completed annually through e-learning. The DOC reviewed staff IPAC training for 2021 and confirmed not all staff had completed IPAC training in 2021.

Sources:
Review of SJHC L003- Leader Certification Compliance Report for IPAC training and interviews with the DOC and other staff. [s. 76. (4)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(d) that the program is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (2).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's infection prevention and control program was updated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practice.

Ministry of Health and Long-Term Care (MOHLTC) – Control of Respiratory Infection Outbreaks in Long Term Care Homes states, "LTCHs must ensure that staff has sufficient supplies of, and quick, easy access to, the PPE required."

During the course of the inspection, inspectors observed five home areas, which were in outbreak. Inspectors noted that most wings had only one PPE cart with gowns, gloves and masks which was located in the middle of the hallway. Staff members had to don full PPE in the middle of the hallway, and then walk down the

hallway to enter resident rooms, past other staff and residents. PPE was not available at the point of care at resident rooms.

On one occasion, Inspector #522 observed no PPE in a hallway and staff were required to walk around to the other part of the wing to access PPE.

On a specific date, PSW #112 was observed leaving a resident room and walking to the end of the hallway to get a pair of gloves as there were only two areas in the hallway with gloves. PSW #112 stated gloves were not easily accessible, as they were placed at a far distance apart in the hallway.

In an interview, SJHC Coordinator for Infection Safety stated PPE supplies should be at the point of care at patient rooms.

In an interview, MLHU Manager - COVID Program - Outbreak and Facilities Team stated best practice was that all PPE was available outside residents' rooms so it was accessible to staff.

Sources:
IPAC observations of the home, review of MOHLTC – Control of Respiratory Infection Outbreaks in Long Term Care Homes dated November 2018, interviews with PSW #112, SJHC Coordinator for Infection Safety and MLHU Manager - COVID Program - Outbreak and Facilities Team and other staff. [s. 229. (2) (d)]

2. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

A) Review of St. Joseph's Health Care (SJHC) "Outbreak Management of Respiratory Infections and Influenza – Non-Acute Care" policy noted control measures were to be implemented as soon as an outbreak was suspected, and Droplet and Contact Precaution signage should be at the entrance to the room or isolation area.

On a specific date, Inspectors #522 and #691945 entered a specific home area and observed staff wearing full personal protective equipment (PPE), including an N95 mask.

Inspectors noted there was no additional precaution signage posted outside resident rooms, and there was no outbreak signage posted upon entrance to the

home area.

In an interview, Personal Support Worker (PSW) #130 stated a specific wing was currently in isolation.

In an interview, Assistant Director of Care (ADOC) #123 stated two wings on a specific home area were currently in isolation. ADOC #123 stated they were covering all of St Mary's and had not posted Droplet and Contact Precaution signage yet. ADOC #123 acknowledged they should have posted signage, but stated staff were swabbing residents and resident safety was first.

In an interview, SJHC Coordinator for Infection Safety stated droplet and contact precaution isolation signage should be posted outside resident rooms as soon as residents became symptomatic, or if they were being tested for COVID-19.

Sources:
IPAC observations of the home, review of SJHC "Outbreak Management of Respiratory Infections and Influenza – Non-Acute Care" policy revised October 15, 2021, PHO - Routine Practices and Additional Precautions in All Health Care Settings, 3rd Edition, November 2012, MOHLTC -Control of Respiratory Infection Outbreaks in Long-Term Care Homes, November 2018, and interviews with PSW #130, ADOC #123, SJHC Coordinator for Infection Safety and other staff.

B) i) Review of SJHC "Routine Practices" policy noted the following in part:
-Gloves were not required for routine health care activities if contact was limited to intact skin;
-Hand hygiene was to be performed before putting on gloves and after glove removal;
-Gloves must be removed and discarded immediately after the activity for which they were used;
-The same pair of gloves must not be used for the care of more than one resident.

On a specific date, Inspector #691945 observed Private Caregiver (PC) #131 wearing disposable gloves while assisting a resident in the dining room. In an interview, PC #131 stated it was their agency's policy to wear gloves at all times in the home. Wearing gloves at all times, when it was not required, caused a risk of cross contamination as PC #131 was not sanitizing their hands.

On a specific date, Inspector #691945 observed PSW #130 in full PPE dispose of

garbage into a garbage bin in the hallway.

PSW #130 was observed removing their gown, left their gloves on, and went into another resident's room. PSW #130 came out of the resident's room, started to remove one glove, was approached by another staff member, and left the hall and came back. PSW #130 then removed their gloves and put on new gloves without sanitizing their hands. PSW #130 stated they had changed a resident’s brief who was under Additional Precautions.

On a home area which was in outbreak, Inspectors #522 and #691945 observed a family member providing care to a resident. The room had Additional Precautions signage posted which required full PPE. The family member was observed with their gown not tied at the waist and without gloves.

On a specific home area, Inspectors #522 and #691945 observed PSW #152 take a gown from the PPE station and walk down the hallway as they donned the gown. PSW #152 was then observed to take gloves out of their pant pocket from under their gown, don the gloves and enter a resident room. PSW #152 told inspectors it was their normal practice to keep gloves in their pockets for easy access.

In an interview, Middlesex-London Health Unit (MLHU) Manager - COVID Program - Outbreak and Facilities Team stated best practice was that gloves should not be stored in a staff members pocket at any time. Expectation would be that staff sanitized their hands and took gloves directly from a box.

ii) Review of SJHC “Routine Practices” policy noted the following in part:
- Masks should securely cover nose and mouth;
- Do not touch mask while wearing it;
- Remove mask correctly immediately after completion of the task and discard;
- Remove mask correctly immediately after contamination has occurred;
- Clean hands before and after removing mask;
- Do not fold mask or place in a pocket for use later or leave it dangling on your neck.

On two occasions during the IPAC tour of the home dietary staff were observed not wearing their surgical mask properly.

On numerous occasions throughout the inspection, staff were observed smoking

outside the home with their surgical mask under their chin, around their wrist, or their N95 mask dangling around their neck.

A staff member was also observed removing their surgical mask, not following proper doffing technique, and carrying their mask in their hand as they walked outside.

On a specific date, Assistant Director of Care (ADOC) #127 went outside with Inspector #522 and observed staff members who were smoking outside, wearing their masks improperly.

ADOC #127 informed the staff members that they should doff their masks when they went outside, and informed staff that they should not wear their masks while they were outside smoking. ADOC #127 told staff that they should not have their surgical masks under their chin, or their N95 mask around their neck.

In an interview, ADOC #127 stated that staff were to doff their N95 masks, and put a new mask on before they left their respective floor. ADOC #127 stated signage had been placed at the entrance/exit to the home which informed staff to remove their masks prior to going outside to smoke.

On a specific date, Personal Care Provider (PCP) #150 was observed entering a resident room. Additional Precaution signage was posted which stated staff were to wear an N95 mask and surgical mask with visor if they did not have eye protection. PCP #150 was wearing full PPE which included an N95 mask, surgical mask and goggles. PCP #150 had eye protection and was not required to wear a surgical mask over their N95 mask.

iii) Review of SJHC “Routine Practices” policy noted PPE, except for an N95 mask, should be doffed at the resident’s doorway or in an anteroom.

On a specific date, Inspector #691945 observed a family member leave a resident room wearing a gown, mask, eye protection and gloves. The family member was observed entering the elevator wearing full PPE and without performing hand hygiene.

On home area which was in outbreak, Inspectors #522 and #691945 observed PSW #125 walk down the hallway past the nurses’ station as they removed their gown. PSW #125’s goggles fell off their head, the PSW caught them and put them

back on, then proceeded to walk down the hallway and disposed of their gown in a hamper and did not perform hand hygiene.

On another home area, PSW #139 was observed exiting a resident room in full PPE. Inspector #522 observed that there was no hamper to doff PPE in the hallway, and PSW #139 had to go down and around to another hallway to doff their PPE. PSW #139 stated there were no other hampers to dispose of their gown and gloves and sometimes they would pull the hamper around with them for easy access.

On several home areas that were in outbreak, Inspectors could not locate a garbage to dispose of reusable PPE when they exited the home area.

On a specific date, resident #008 approached Inspector #522 with concerns that garbage bins to dispose of gowns, were placed right beneath the elevator button on their floor. Resident #008 was in a wheelchair and they had to reach over the garbage to push the elevator button.

Observations of all home areas noted tall garbage bins without lids had been placed under elevator buttons with signage to dispose of gowns.

In an interview, the ED stated the garbage bins should not be under the elevator button, and had the bins moved.

On home area which was in outbreak, Inspectors #522 and #691945 observed PCP #150 leave a resident room who was on additional precautions, in full PPE, carrying a tray. PCP #150 walked through the home area to the dining room and proceeded to return to the resident’s room.

On two occasions, a used gown was observed hanging out of a dirty hamper, which was beside a PPE cart.

In an interview, MLHU Manager - COVID Program - Outbreak and Facilities Team stated donning and doffing should be completed at the residents’ room. Best practice was that a hamper and garbage with a lid was available to doff PPE prior to exiting a resident room.

C) i) Review of SJHC “Hand Hygiene” policy noted in part that residents might require assistance in performing hand hygiene before eating.

On a home area which was in outbreak, Inspector #522 observed Resident Support Aide (RSA) #164 give a cookie to a resident. RSA #164 did not assist the resident to sanitize their hands.

ii) Review of SJHC "Routine Practices" policy noted the following in part:
-Perform hand hygiene before putting on gloves and after glove removal;
-Clean hands before and after removing mask;
-After removing gown perform hand hygiene prior to removing PPE from face.

On several occasions, staff members were observed either donning or doffing PPE without performing hand hygiene, as required.

During the course of the inspection, observations noted donning and doffing PPE signage was posted on the walls throughout the home areas. Review of the signage noted the picture procedure for doffing PPE, did not include the use of hand hygiene during doffing.

Review of SJHC Patient Safety: Hand Hygiene Compliance Audit Report by Unit 2021-22 Q3 noted in summary that 89.3% of Mount Hope staff that were observed performed the four moments of hand hygiene.

In an interview, ADOC #127 acknowledged the home was not in 100% compliance for hand hygiene in most home areas. ADOC #127 acknowledged that staff should perform hand hygiene when they donned and doffed PPE.

Sources:
IPAC observations of the home, review of Review of SJHC "Hand Hygiene" policy revised November 1, 2021, SJHC "Routine Practices" policy revised March 3, 2021, SJHC Patient Safety: Hand Hygiene Compliance Audit Report by Unit 2021 -22 Q3, and interviews with RSA #164, PSW #112, PSW #149, ADOC #127, the DOC, and the ED.

D) On a specific date, resident #006 and a visitor were observed together in the hallway entering resident #006's bedroom. There was additional precaution signage beside the bedroom door.

During an interview with PCP #102 they stated that the room that was entered was a double room and only one of the residents were on isolation.

As per record review, resident #006 was on not in isolation. Their roommate resident #007 was currently in isolation.

Directive #3 for Long-Term Care Homes under the Long- Term Care Homes Act, 2007, Effective Date of Implementation: December 24, 2021, states that if a resident requiring isolation cannot be placed in a single room, the other resident must also be placed in isolation under additional precautions.

During an interview with the IPAC lead, ADOC #127, they stated that residents in a shared bedroom would both need to be isolated. ADOC #146 stated that both resident #006 and resident #007 should have been isolated the same amount of time and it was incorrect for one resident to be out of isolation while the other still required it.

Not following the home's infection prevention and control (IPAC) policies put residents and staff at risk of potentially spreading healthcare associated infections, including COVID-19. [s. 229. (4)]

3. The licensee has failed to ensure that the home’s hand hygiene (HH) program was implemented in accordance with the Ontario evidence-based HH program, Just Clean Your Hands (JCYH) to support resident HH when entering and leaving a common gathering area of the home.

Review of the “Just Clean Your Hands” Implementation Guide stated alcohol based hand rub (ABHR) should be available in common areas where residents gather, so they can clean their hands.

During the course of the inspection, several residents were observed smoking outside in the courtyard between the hallway coming from MV and the main lobby of SM. There was no ABHR in the area of the courtyard for residents to use. Residents were required to take the ramp into MV or go to the cafe in the lobby to access ABHR.

In an interview, resident #014 stated there used to be hand sanitizer near the doors to the courtyard, but it had been taken away and now there was no where to sanitize their hands.

In an interview, the Executive Director (ED) stated all entrances and exits should

have ABHR, except the courtyard smoking area, as the ED had been told by the fire department not to have flammable items near the smoking area. The ED stated there should be ABHR just a short distance to left and right of the courtyard.

In an interview, the Middlesex-London Health Unit (MLHU) Manager - COVID Program - Outbreak and Facilities Team stated ABHR should available for residents entering the home from an outdoor smoking area, and their was no risk for a small dispenser to be placed in the area by the courtyard.

In an interview, the London Fire Department (LFD) Fire Prevention Inspector/Investigator stated there was no concern to have a small container of ABHR located near the doors to the courtyard used by residents for smoking.

Sources:
IPAC observations of the home, review of the JCYH Implementation Guide and interviews with resident #014, MLHU Manager - COVID Program - Outbreak and Facilities Team, LFD Fire Prevention Inspector/Investigator and the ED. [s. 229. (9)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 003

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's infection prevention and control program is updated in accordance with evidence-based practice regarding accessibility of PPE and to ensure that the home's hand hygiene program is implemented in accordance with evidence-based practice, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius.

On January 10, 2022, during a tour of the home, Inspectors had concerns that the temperatures on SM third floor home area might be below 22 degrees Celsius (°C).

On January 10, 2022, Inspector #691945 took temperature readings with a digital pocket thermometer of the following SM home areas and noted the following:

Fourth floor - Three common areas ranged from 19.5 to 21.6 °C.

Third floor – Five common areas ranged from 20.9 to 21.7 °C. Temperatures measured in three resident rooms ranged from 20.0 to 21.7 °C.

On January 21, 2022, at 1230 hours, Inspector #691945 observed Stationary Engineer (SE) #155 measure temperatures on SM home areas using a thermal gun and noted the following:

Fourth floor - Three common areas ranged from 20.1 to 21.8 °C.

Third floor – Three common areas ranged from 15.9 to 18.3 °C. Temperatures measured in four resident rooms ranged from 18.7 to 21.4 °C.

On January 24, 2022, Inspector #691945 observed SE #155 and Building Equipment Operator #158 measure temperatures on SM home areas using a thermal gun. The third floor Activity Room measured 19.3 °C. SE #155 stated there was an issue with the heating system in the Activity Room that required repairs.

In an interview, SE #155 stated there were temperature sensors in SM's hallways that could be monitored remotely, but they did not have remote temperature sensors for resident rooms.

Sources:
Review of temperature measurements on SM home areas, interviews with resident #009 and #010, SE #155, Building Equipment Operator #158 and the ED. [s. 21.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is maintained at a minimum temperature of 22 degrees Celsius, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed within one business day when resident #003 and resident #004 had a fall that resulted in hospitalization and a significant change in health condition.

A) Resident #003 had a fall and was transferred to the hospital. The home was made aware that day, that resident #003 had a change in condition. The home informed the Director two business days after the incident occurred.

B) Resident #004 had a fall and was transferred to hospital the following day. The home was made aware that day, that resident #004 had a change in condition. The home informed the Director three business days after the incident occurred.

Sources: Critical Incident Reports, resident #003's and resident #004's clinical records, and interviews with PSW #121, RN #122, and ADOC #123. [s. 107. (3) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Director is informed within one business day, when a resident has a fall that results in hospitalization and a significant change in health condition, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's "Hand Hygiene" policy was in compliance with requirements under the LTCH Act.

O. Reg 79/10 s. 219. (1) states "The intervals for the purposes of subsection 76 (4) of the Act are annual intervals."

O. Reg 79/10 s. 219. (4) states, "The licensee shall ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes hand hygiene…"

Review of St. Joseph's Health Care (SJHC)'s "Hand Hygiene" policy stated that all staff were required to compete Infection and Prevention & Control Core Competency e-learning training on Hand Hygiene every two years.

In an interview, the Director of Care (DOC) stated the home followed SJHC's "Hand Hygiene" policy. The DOC stated their staff completed hand hygiene training annually, although the policy indicated training was to be completed every two years.

The DOC confirmed that the home's "Hand Hygiene" policy did not comply with the Act, which required annual hand hygiene training.

Sources:
Review of SJHC's "Hand Hygiene" policy revised November 1, 2021, and interview with the DOC. [s. 8. (1)]

Issued on this 2 nd day of March, 2022 (A1)

[redacted]

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.