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

London District
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London, ON, N6A 5R2
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Public Report

Report Issue Date: January 20, 2025
Inspection Number: 2025-1137-0001
Inspection Type: Critical Incident
Licensee: Vigour Limited Partnership on behalf of Vigour General Partner Inc.
Long Term Care Home and City: Secord Trails Community, Ingersoll

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 16, 17 & 20th, 2025
The inspection occurred offsite on the following date: January 20, 2025

The following intake(s) were inspected:

- Intake: #00134572/ Critical Incident (CI) #2628-000023-24 regarding an outbreak

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 the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, issued by the Director, was complied with.

In accordance with Additional Precautions 9.1 (f) under the IPAC Standard for Long-Term Care Homes (April 2022, revised September, 2023), the licensee has failed to ensure staff appropriately removed and disposed of their personal protective equipment (PPE) upon exiting a resident room, which had droplet/contact precautions implemented at the time.

1. Staff did not appropriately remove PPE upon exiting a residents room with additional precautions.
2. Staff disposed of their PPE into a common laundry and garbage receptacle, down the hall from a residents room.

Sources:

observations of staff, review of the posted PPE signage, staff interviews

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)

Infection prevention and control program

s. 102 (9) The licensee shall ensure that on every shift,

(b) the symptoms are recorded, and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The licensee failed to ensure a residents symptoms indicating the presence of an infection were recorded on every shift, nor was the resident immediately isolated to prevent the spread of infection.

Sources:

review of progress notes, and staff interviews.