

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

Central West District

609 Kumpf Drive, Suite 105 Waterloo, ON, N2V 1K8 Telephone: (888) 432-7901

Original Public Report

Report Issue Date: October 11, 2024

Inspection Number: 2024-1029-0003

Inspection Type:

Critical Incident

Follow up

Licensee: CVH (No. 2) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.) Long Term Care Home and City: Parkview Manor Health Care Centre, Chesley

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 7-9, 2024

The following intake(s) were inspected:

- Intake: #00123761 related to Covid-19 outbreak
- Intake: #00124694 Follow-up #: 1 O. Reg. 246/22 s. 19, Safe and Secure Home, CDD September 26, 2024

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2024-1029-0001 related to O. Reg. 246/22, s. 19



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The following Inspection Protocols were used during this inspection:

Safe and Secure Home Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: CMOH and MOH

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

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 failed to ensure that recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act were followed in the home. Specifically, the licensee did not follow the Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings, effective April 2024.

Rationale and Summary

The home was declared to be in outbreak in August 2024.

During a suspected or confirmed outbreak, high-touch surfaces are to be cleaned



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and disinfected at minimum twice per day.

Upon review of the daily high-touch surface cleaning checklist, cleaning of hightouch surfaces was not completed twice per day during the time the home was in outbreak.

The IPAC Lead acknowledged that the high-touch surface cleaning checklist was incomplete or completed once per day, but should have been completed twice per day.

By failing to ensure high-touch surfaces were cleaned twice per day during a confirmed outbreak, there was increased risk of transmission to residents within the home.

Sources: Critical Incident report, daily high-touch surface cleaning checklist, interview with IPAC Lead