Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ottawa District
347 Preston Street, Suite 410
Ottawa, ON, K1S 3J4
Telephone: (877) 779-5559

Original Public Report

Report Issue Date: April 16, 2024	
Inspection Number: 2024-1008-0001	
Inspection Type: Critical Incident	
Licensee: DTOC II Long Term Care LP, by its general partner, DTOC II Long Term Care MGP (a general partnership) by its partners, DTOC II Long Term Care GP Inc. and Arch Venture Holdings Inc.	
Long Term Care Home and City: Champlain Long Term Care Residence, L'Orignal	
Lead Inspector Lisa Kluke (000725)	**Inspector Digital Signature**
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on April 3-4, and 8-9, 2024

The following intake(s) were inspected:

- Intakes #00109425 and #00111433 were related to outbreaks declared affecting all residents in the home.

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

Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Accommodation services

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)
Accommodation services
s. 19 (2) Every licensee of a long-term care home shall ensure that,
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

The licensee has failed to ensure that the home, furnishings and equipment such as wooden handrails were maintained in a safe condition and in a good state of repair.

Rationale and Summary:
This inspection was related to the five critical incidents of outbreaks occurring in the home over from August 2023 to March 2024 to review infection prevention and control practices. It was observed in the home, wooden handrails that had not been maintained in a good state of repair as the varnish has been worn off exposing the raw wood surface. The raw surface of wood noted on both sides of the resident wing hallway, had no varnish coating as the varnish has been worn off which has left the wood itself exposed as an unsealed high touch surface.

A housekeeper reported these wooden handrails were quite used whereby the varnish was removed and porous wood noted beneath as they use a stronger sanitizing product to clean high touch surfaces for infection prevention and control practices.

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The Environmental Services Manager indicated they purchased new handrails however they were not on the current preventative maintenance schedule yet due to other maintenance priorities.

Failing to have sealed handrails posed a potential risk for infection prevention and control for bacteria growth in the unsealed surface areas that could cause cross contamination infecting residents, visitors and staff in the home.

Sources: Observation of resident handrails and interviews with a housekeeper and the Environmental Services Manager. [000725]