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

Hamilton District
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Hamilton, ON, L8P 4Y7
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Original Public Report

Report Issue Date: November 17, 2022
Inspection Number: 2022-1334-0001
Inspection Type: Complaint Follow-up
Licensee: AXR Operating (National) LP, by its general partners
Long Term Care Home and City: Ridgeview, Stoney Creek

Lead Inspector	**Inspector Digital Signature**
Klarizze Rozal (740765)	Klarizze Mae S Rozal Digitally signed by Klarizze Mae S Rozal Date: 2022.11.21 10:41:37 -05'00'

Additional Inspector(s)
Parminder Ghuman (706988)

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 1-4, 2022, November 7-8, 2022, November 15, 2022

The following intake(s) were inspected:

- Intake: #00001230- Follow-up Compliance Order related to neglect.
- Intake: #00002473- Complaint related to denied admission.
- Intake: #00006087- Complaint related to staffing shortage affecting resident care.

Previously Issued Compliance Order(s)

Legislative Reference	Inspection #	Order #	Inspector (ID) who complied the order
LTCHA, 2007, s. 19 (1)	#2021_689586_0023	001	Klarizze Rozal #740765

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Admission, Absences and Discharge
Resident Care and Support Services

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 (15) 2].

The licensee failed to ensure that the designated infection prevention and control (IPAC) lead worked regularly in that position on site at the home, with a licensed bed capacity of more than 69 beds but less than 200 beds, at least 26.25 hours per week.

Rationale and Summary

A full-time Infection Control Manager job posting for the home was posted.

The Executive Director #100 (ED) confirmed the home was actively recruiting for the IPAC lead position. They verified they did not have an IPAC lead working regularly on-site. They stated they assumed the role and worked 25 hours per week as an IPAC lead in the home of 120 beds.

The residents were placed at risk for transmission of infection without an IPAC lead designated to work the minimum required weekly hours.

Sources: Job Posting and interview with ED #100.

[740765]