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

Toronto District
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Original Public Report

Report Issue Date: September 7, 2023	
Inspection Number: 2023-1052-0002	
Inspection Type: Critical Incident	
Licensee: Vigour Limited Partnership on behalf of Vigour General Partner Inc.	
Long Term Care Home and City: Rockcliffe Care Community, Scarborough	
Lead Inspector Manish Patel (740841)	**Inspector Digital Signature** Manishkumar C Patel Digitally signed by Manishkumar C Patel Date: 2023.09.07 16:13:31 -04'00'
Additional Inspector(s) Patricia McFadgen (000756)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 31, 2023 and September 1, 5 and 6, 2023.

The following intake(s) were inspected:

- Intake: #00086781 [CI #2131-000013-23], Intake: #00088110 [CI #2131-000016-23], Intake: #00088234 [CIS #2131-000017-23] and Intake: #00089334 [CI #2131-000020-23] - related to Fall resulting in injuries.
- Intake: #00092753 [CI #2131-000022-23], Intake: #00093694 [CI #2131-000023-23] and Intake: #00096278 [CI #2131-000027-23] - related to outbreak.

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

Infection Prevention and Control
Falls Prevention and Management

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 (7) 11.

The licensee has failed to ensure that the infection prevention and control lead (IPAC lead) carried out their responsibilities related to the hand hygiene program.

The IPAC lead failed to ensure that that there is in place a hand hygiene program in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard). Specifically, the IPAC lead did not ensure that hand hygiene agents, including 70-90% Alcohol-Based Hand Rub (ABHR) was easily accessible at point-of care, and any staff providing direct resident care had immediate access to 70-90% ABHR as required by Additional Requirement 10.1 under the IPAC Standard.

Rationale and Summary
Upon review of Critical Incident report (CI) regarding outbreak in the home, it was noted that the home had outbreak in July 2023 and August, 2023.

During an observation, it was noticed that a number of rooms, had hand sanitizer unit in the room but were not working. Observations on a different unit, revealed that hand sanitizers were not working in a number of rooms. In another room, the unit was working but was not dispensing sanitizer. Observation on another unit on another day revealed that hand sanitizers in a number of rooms were not working. A repeat observation on another day revealed that hand sanitizers were still not working in number of rooms.

While Infection Prevention And Control (IPAC) lead acknowledged that the hand sanitizers at bed side, which is point-of-care where most care to the residents is delivered, shall be in working order, interview with Registered Nurse (RN), Personal Support Workers (PSWs) acknowledged that the hand sanitizer in the room were not working and it did pose risk of cross contamination.

As acknowledged by the staff, not having hand sanitizers as required by IPAC standard 10.1 at point-of-care, increased the risk of transmission of infectious disease.

Sources
Review of CI, IPAC Standards, Hand Hygiene Policy IX-G-10.10, Multiple observations on the floor, Interview with IPAC Lead, PSWs, and RN.
[740841]