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

Central West District
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Original Public Report

Report Issue Date: December 4, 2024
Inspection Number: 2024-1509-0005
Inspection Type: Complaint
Licensee: Saint Luke's Place
Long Term Care Home and City: Saint Luke's Place, Cambridge

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 5-8, 2024

The following intake(s) were inspected:

- Intake: #00126266 -related to improper care.
- Intake: #00127964 - related to improper care and neglect of resident.

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

Continence Care
Medication Management
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

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 that the standard issued by the Director with respect to IPAC was implemented.

Rationale and Summary

According to the IPAC Standard for LTCHs dated April 2022, revised September 2023, section 9.1 b), the licensee shall ensure that routine practices and additional precautions are followed in the IPAC program.

At minimum, routine practices shall include hand hygiene, including, but not limited to the four moments of hand hygiene (before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact).

Staff members failed to adhere to the hand hygiene protocols as required:

- A staff member was observed wearing gloves while assisting a resident in their wheelchair. They continued wearing the same gloves and approached another resident to inquire if they needed to be toileted, then proceeded to remove only the right-hand glove to operate the computer.

- Staff members on the same home area were seen donning gloves while transporting trays from the resident's room, emptying them, and placing the utensils into the dirty dish cart and escorting residents in their wheelchair to the dining room while wearing gloves.

Hand Hygiene (HH) audit indicated that staff donned gloves outside of the resident room and received re-education concerning the four moments of HH and the proper single glove use.

Staff member stated that the expectation was to remove the gloves in the room after toileting the resident and preform HH, however, they failed to adhere to this protocol.

IPAC Lead also stated that staff were not supposed to wear gloves to deliver tray or to transport residents.

Failure to perform hand hygiene properly posed a potential risk for the spread of infection.

Sources: HH and Glove audits, observations and interview with staff members.