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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: February 5, 2024

Inspection Number: 2024-1037-0001

Inspection Type:
Complaint
Critical Incident

Licensee: CVH (No. 8) 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: Seaforth Long Term Care Home, Seaforth

Lead Inspector	**Inspector Digital Signature**
Christie Birch (740898)	Christie Birch Digitally signed by Christie Birch Date: 2024.02.05 12:34:31 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 25, 26, 29, 30, 2024

The following intake(s) were inspected:

- Intake: #00103802 - CI-1135-000030-23 Fall of resident with injury.
- Intake: #00103825 - Complaint related to resident care.

The following intake was completed during this inspection:

- Intake: #00101558 - CI-1135-000027-23 Fall of resident with injury.

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 (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 any standard issued by the Director with respect to Infection Prevention and Control (IPAC) was implemented.

A) Specifically, the licensee has failed to ensure that surveillance information was tracked and entered into the surveillance database and/or reporting tools; as required by Additional Requirement 3.1 (f) under the IPAC Standard for Long-Term Care Homes.

Rationale and Summary

The IPAC Standard for Long-Term Care Homes (LTCHs), indicated under section 3.1

(f) that the licensee shall ensure that surveillance information is tracked and entered into the surveillance database and/or reporting tools.

The Outbreak-Respiratory Line List noted that the home was declared in an outbreak by Huron Perth Public Health (HPPH) on November 25, 2023. This document also defined the case definition of symptoms related to outbreak as "A resident or staff member with any new, worsening, or different from an individual's normal symptoms (i.e. allergies) who are experiencing any one of the following symptoms: Fever and/or chills, cough or barking cough, shortness of breath, decreased or loss of smell or taste, muscle aches/joint pain, fatigue, sore throat, runny nose/stuffy nose (i.e. congestion), headache, nausea/vomiting and/or diarrhea."

The progress notes of two residents noted that symptoms in accordance with the case definition, were exhibited during the outbreak.
In a review of the Respiratory-Outbreak Resident Line List, it was noted that neither of the two residents were on the list.

Policy No: 8.8 Managing Outbreaks stated: “A line list of cases must be initiated at the onset of a suspected or confirmed outbreak to keep track of residents and staff displaying signs and symptoms consistent with the case definition. The document must be updated daily and shared with the local Public Health Unit (PHU). ”

In an Interview with the Public Health Nurse (PHN), they confirmed both residents were not on the line list, and they had not been made aware of the symptoms they exhibited consistent with the case definition. They also confirmed that any resident with at least one symptom as listed on the line list tab, during the outbreak, met the case definition and should have been added to the line list and communicated to HPPH by way of the line list.
The Director of Nursing and Personal Care (DNPC) confirmed neither resident had been added to the line list and should have been.

In an interview with the IPAC lead, they confirmed that residents who met the case definition should be added to the line list.

There was risk to residents related to residents not being added to the line list.

Sources: Resident clinical records; IPAC Standard for Long-Term Care Homes, Revision date September 2023, Outbreak-Respiratory Line List; Policy No: 8.8 Managing Outbreaks- Issue date June 13, 2023, revision date June 30, 2023; Outbreak Control Measures for Long-Term Care Homes and Retirement Homes, dated November 25, 2023; Interviews with staff.
[740898]