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: October 29, 2024
Inspection Number: 2024-1037-0003
Inspection Type: 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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s):
October 22, 23 and 25, 2024
The inspection occurred offsite on the following date(s): October 24, 2024
The following intake(s) were inspected:

- Intake: #00126430 related to a - COVID Outbreak

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

Infection Prevention and Control

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 failed to ensure compliance with any standard or protocol issued by the Director with respect to infection prevention and control; related to the IPAC Standard section 9 Routine Practices:

A: 9.1(b) Hand hygiene, including, but not limited to, at 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);

B: 9.1 (d) Proper use of PPE, including appropriate selection, application, removal, and disposal;

Rationale and Summary:
While in the home, an inspector with the Ministry of Long Term Care observed two staff not comply with Routine Practices:

A) A Personal Support Worker (PSW) acknowledged a missed moment of hand hygiene after contact with a resident environment. The PSW failed to

perform hand hygiene after touching multiple surfaces to put away personal clothing and laundered items in a room with posted additional contact precautions. When the PSW failed to perform hand hygiene after interacting with the resident environment they increased risk of transmitting infectious pathogens to other residents.

B) Another Personal Support Worker (PSW) increased risk of exposure to bodily fluids when they failed to wear gloves while they carried a soiled brief to the dirty utility and placed a resident's personal items into the laundry hamper. In an interview with the PSW, they acknowledged they should have been wearing gloves at the time.

When two staff did not follow all "Routine Practices" there was increased risk of transmission of infectious pathogens and exposure to bodily fluids. There was no outbreak at the time of inspection, so risk is low. There was potential impact to multiple/ all residents with both failures to follow routine practices.

Sources:
Observation made by an inspector from MLTC, staff Interviews, and review of the LTCH "Routine Practices" policy.