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: February 7, 2024
Inspection Number: 2024-1253-0001
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: Shelburne Long Term Care Home, Shelburne

Lead Inspector	**Inspector Digital Signature**
Daniela Lupu (758)	Daniela Lupu Digitally signed by Daniela Lupu Date: 2024.02.08 11:08:06 -05'00'

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: January 29-31, and February 1- 2, 2024

The following intake was inspected:

- Intake #00102925, related to an outbreak

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

Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Housekeeping

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (iii)
Housekeeping
s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(iii) contact surfaces;

The licensee has failed to comply with the housekeeping procedures for cleaning and disinfection of contact surfaces in resident rooms.

Rationale and Summary

The home's housekeeping procedure for cleaning and disinfection of contact surfaces in resident rooms directed staff to use a disinfectant cleaner and a clean cloth and change the cloth for each resident space.

On two separate occasions, two housekeeping staff did not follow the home's procedure when they cleaned and disinfected the high touch areas in three resident shared rooms.

The home's Infection Prevention and Control (IPAC) Lead said cloths used to clean and disinfect contact surfaces on different resident bed spaces should be changed

for each resident bed space area.

By staff not following the home's cleaning and disinfection procedure of high touch areas in resident rooms, there was a potential risk to spread harmful microorganisms amongst residents.

Sources: observations of cleaning in three resident rooms, the home's policy Cleaning Routine -Resident Room and Washroom policy, and interviews with two housekeeping staff, and the home's IPAC Lead. [758]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #002 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 Infection Prevention and Control (IPAC), was implemented.

Rationale and Summary

According to O. Reg. 246/22, s. 102 (2) (b), the licensee is required to implement any standard or protocol issued by the Director with respect to IPAC.

The IPAC Standard for Long-Term Care Homes (LTCHs), revised in September

2023, section 9.1 indicates the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum, Routine Practices should include hand hygiene, including but not limited to, before and after resident environment contact and proper use of PPE, including appropriate selection, and application. Additional Precautions should include at minimum additional PPE requirements, including appropriate selection and application.

i) A housekeeping staff did not wear the appropriate PPE and did not perform hand hygiene as required when they cleaned and disinfected a resident room where Routine Precautions were in place.

The home's IPAC Lead said staff should wear the required PPE for Routine Precautions when cleaning and disinfecting surfaces in resident rooms and perform hand hygiene after contact with resident environment and soiled equipment.

ii) The home's environmental policy documented staff should perform hand hygiene before cleaning and disinfection of resident rooms and wear the appropriate PPE according to the type of Additional Precautions.

Southbridge Care Homes Additional Precautions signage was posted on the wall by the entrance to a resident room. The signage directed staff to wear specific PPE.

On one occasion, a housekeeping staff did not wear the appropriate PPE and did not perform hand hygiene as required when they cleaned and disinfected a resident room where Additional Precautions were in place.

The home's IPAC Lead said staff should wear the PPE as indicated in the home's Additional Precautions signage when cleaning and disinfecting resident rooms, due to risk of exposure to harmful microorganisms in the residents' environment. They

also said staff should perform hand hygiene before and after contact with resident environment and soiled items.

Staff not following the appropriate practices related to Routine and Additional Precautions, regarding PPE use and hand hygiene, posed a potential risk for spreading harmful microorganisms throughout the home.

Sources: observations of cleaning and disinfection of two resident rooms, Southbridge Care Homes-Contact Precautions signage, IPAC Standard (September 2023), the home's Environmental and High-touch Surface Cleaning and Disinfection policy, and interviews with a housekeeping staff and the home's IPAC Lead. [758]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The licensee has failed to ensure that a respiratory outbreak was immediately reported to the Director.

Rationale and Summary

A respiratory outbreak was declared at the home by the Public Health Unit (PHU). The outbreak was reported to the Director a day later after it was declared.

The home's IPAC Lead said the outbreak was not reported immediately as required.

By not reporting immediately the respiratory outbreak to the Director, may limit the Director's ability to respond to the incident in a timely manner.

Sources: a critical incident report, the home's Daily Outbreak or Suspected Outbreak Report, and interviews with the home's IPAC Lead and the ADOC. [758]