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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: October 20, 2023	
Inspection Number: 2023-1197-0002	
Inspection Type: District Initiated	
Licensee: Jarlette Ltd.	
Long Term Care Home and City: Temiskaming Lodge, Haileybury	
Lead Inspector Karen Hill (704609)	**Inspector Digital Signature** Karen L Hill Digitally signed by Karen L Hill Date: 2023.11.01 11:43:44 -04'00'

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: October 10-11, 2023

The following intake was inspected:

- North District Initiated Infection Prevention and Control (IPAC) Inspection

The following **Inspection Protocol** was 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)

The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control (IPAC). Specifically, the licensee failed to ensure that routine practices related to hand hygiene were followed in the IPAC program, as was required by Additional Requirement 9.1 (b) under the IPAC Standard.

Rationale and Summary

According to 9.1 (b) of the IPAC Standard for Long Term Care Homes (LTCHs), revised September 2023, for routine practices, the licensee was to ensure that hand hygiene included but was 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).

Two staff members were observed exiting resident rooms holding soiled linens and a garbage bag. The staff members disposed of the linens and while still holding the garbage bags, touched other surfaces in the resident home area without prior hand hygiene.

The staff members and the IPAC lead acknowledged that hand hygiene was not performed as per the four moments of hand hygiene and should have been.

There was risk to the residents in the home when the licensee failed to ensure that the staff members followed routine practices by performing hand hygiene as required.

Sources: Observations; review of the home's policies titled, LTC Hand Hygiene, and LTC Routine Practices, JYCH program titled, Just Clean Your Hands Program, Your 4 moments for Hand Hygiene for LTCH, and the Public Health Ontario: Provincial Infectious Diseases Advisory Committee (PIDAC), Routine Practices and Additional Precautions in All Health Care Settings; and interviews with the IPAC lead and other staff members.

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