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

Public Report

Report Issue Date: December 2, 2024
Inspection Number: 2024-1051-0004
Inspection Type: Critical Incident
Licensee: Axium Extendicare LTC II LP, by its general partners Extendicare LTC Managing II GP Inc. and Axium Extendicare LTC II GP Inc.
Long Term Care Home and City: Iler Lodge, Essex

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 25-27, 2024.

The following intake(s) were inspected:
Intake: #00129744 / CI#2129-000040-24 related to an 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 that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Introduction

The Licensee failed to ensure that any standard or protocol issued by the Director with respect to infection prevention and control was implemented.

Rationale and summary

According to the Infection Prevention and Control Standard for Long-Term Care Homes issued by the Director, revised September 2023, section 9.1 (b) states: "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)."

A Critical Incident report was sent to the Director related to an outbreak.

During observations, it was noted that staff did not perform hand hygiene in between performing care to the residents or after providing care to a resident.
During an interview with a resident, it was affirmed that staff did not perform hand hygiene prior to providing certain care to this resident.

Failure to complete the hand hygiene exposes the residents at risk of transmission of infectious agents.

Sources: observations and interview with residents

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