

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**Rapport d'inspection en vertu de
la Loi de 2007 sur les foyers de
soins de longue durée**

**Long-Term Care Operations Division
Long-Term Care Inspections Branch**

**Division des opérations relatives aux
soins de longue durée
Inspection de soins de longue durée**

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 9, 2021	2021_875501_0011	005860-21	Critical Incident System

Licensee/Titulaire de permis

AXR Operating (National) LP, by its general partners
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 Mississauga ON L4W
0E4

Long-Term Care Home/Foyer de soins de longue durée

Winbourne Park
1020 Westney Road North Ajax ON L1T 4K6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SUSAN SEMEREDY (501)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): May 18, 19, 20, 21, 2021.

**The following intake was inspected during this critical incident inspection:
Intake #005860-21 related to falls prevention.**

Inspector #746 and #706026 were also present during this inspection.

During the course of the inspection, the inspector(s) spoke with the Infection Prevention and Control (IPAC) Lead, Environmental Services Manager (ESM), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) and residents.

During the course of the inspection, the inspectors observed resident and staff interactions and infection prevention and control practices. Inspectors also reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

**The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control**

During the course of this inspection, Non-Compliances were issued.

1 WN(s)

1 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

The LTCH's Infection Prevention and Control (IPAC) program required staff to wear appropriate personal protective equipment (PPE) when entering a room with precautions. Signage on a shared room indicated there were precautions. On two different occasions, staff members were observed exiting the room without wearing the appropriate PPE and disinfecting their eye protection. An interview with the IPAC Lead confirmed that the above staff members should have put on and taken off appropriate PPE and disinfected their eye protection as was the protocol in the home. It was also noted that there was a small fan which was oscillating and directed towards the resident who had precautions. An interview with the IPAC Lead acknowledged the fan should not have been in use in a room that had such precautions as recommended by Public Health Ontario.

Not wearing appropriate PPE in a room with precautions risks spreading infectious disease to others. The use of fans in such rooms could propel infectious droplets and is not recommended.

Sources: Observations, interviews with the IPAC Lead and and Public Health Ontario document "The Use of Portable Fans and Portable Air Conditioning Units during COVID-19 in Long-term Care and Retirement Homes." [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

Issued on this 9th day of June, 2021

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.