Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report under the
Fixing Long-Term Care Act, 2021

Central East Service Area Office
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Original Public Report

Report Issue Date July 20, 2022
Inspection Number 2022_1438_0001
Inspection Type
☒ Critical Incident System ☒ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Southlake Residential Care Village

Long-Term Care Home and City
Southlake Residential Care Village, Newmarket, Ontario

Lead Inspector
Julie Dunn (706026)

Inspector Digital Signature
Julie Dunn Digitally signed by Julie Dunn Date: 2022.07.20 14:41:40 -04'00'

Additional Inspector(s)
Tiffany Forde (741746) and Rita LaJoie (741754) were present during the inspection.

INSPECTION SUMMARY

The inspection occurred on the following date(s): June 14, 15, 16, 17, 20, 2022

The following intake(s) were inspected:

Intake #011165-22 - complaint related to a hip fracture;
Intake #008160-22 – complaint related to a hip fracture;
Intake #006362-22 – CI report related to a hip fracture.

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Pain Management
- Prevention of Abuse and Neglect
- Safe and Secure Home

INSPECTION RESULTS

During the course of this inspection, the inspector(s) made relevant observations, reviewed records and conducted interviews, as applicable.

WRITTEN NOTIFICATION [IMPLEMENTATION OF IPAC STANDARD]

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 ensure the implementation of any standard or protocol issued by the Director with respect to infection prevention and control (IPAC). Specifically, the licensee failed to ensure the staff used appropriate personal protective equipment (PPE) for a resident on additional precautions for an infection; and failed to ensure the staff provided support for residents to perform hand hygiene prior to receiving meals.

Rationale and Summary

An additional precautions sign was posted on the door of a resident's room. A staff entered the resident's room with equipment, then exited the room five minutes later, while removing gloves. The staff confirmed that they assisted the resident with another staff, and stated they were aware of the additional precautions for the resident. They stated they only needed to wear additional PPE if providing care for the resident. The IPAC lead confirmed the resident was on additional precautions for an infection. A Registered Practical Nurse (RPN) confirmed the staff should have worn additional PPE for assisting the resident, as the resident was on additional precautions for an infection.

On two different dates, residents arrived in the dining room areas independently and assisted with walkers and wheelchairs for meal service. There was no resident hand hygiene observed; staff did not support residents to perform hand hygiene prior to receiving their meals. Residents ate sandwiches and bread with their hands. The IPAC lead stated the long-term care home's expectations for supporting and assisting residents with hand hygiene, at minimum, was before and after meals, before and after snacks, and before and after programs.

In failing to ensure the proper use of PPE for a resident who was on additional precautions for an infection, there was risk of spreading the infection to other residents and staff.

Sources:
Observations of the resident's room; interviews with IPAC lead and other staff; observations at meal times.
(706026)