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

Hamilton District
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Original Public Report

Report Issue Date: December 15, 2022	
Inspection Number: 2022-1458-0002	
Inspection Type: Follow up	
Licensee: St. Joseph's Health System	
Long Term Care Home and City: St. Joseph's Villa, Dundas, Dundas	
Lead Inspector Lisa Bos (683)	**Inspector Digital Signature** Lisa Bos Digitally signed by Lisa Bos Date: 2022.12.29 16:17:01 -05'00'

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
December 5-9, 2022

The following intake(s) were inspected:

- Intake: #00006744-Follow-up to CO#001 from inspection #2022_877632_0003 regarding O. Reg. 79/10 s. 36., CDD Oct 11, 2022

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance.

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 79/10	s. 36	2022_877632_0003	001	Lisa Bos (683)

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

Falls Prevention and Management
Infection Prevention and Control
Resident Care and Support Services

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, dated April 2022, was implemented.

Rationale and Summary
The IPAC Standard for Long-Term Care homes, indicated under section 9.1 that additional precautions shall include (e) point-of-care signage indicating that enhanced IPAC control measures were in place.

Signage for droplet/contact precautions was posted on the door to a resident's room. Their written plan of care indicated that they required contact precautions, and there was no documentation that droplet precautions were required.

The IPAC lead acknowledged that the resident required contact precautions and that incorrect signage was posted. The signage was removed, and the appropriate signage was posted. There was no impact to the resident and no risk as the signage was beyond what the resident required.

Sources: Observations; a resident's clinical record; interview with the IPAC lead
[683]

Date Remedy Implemented: December 8, 2022

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 18.

The licensee has failed to ensure that a resident's right to be afforded privacy in caring for their personal needs was fully protected and promoted.

Rationale and Summary:
The tub room door on a resident home area was observed to be wide open, and a Personal Support Worker (PSW) was observed giving a resident a bath. The privacy curtain in the tub room was also open.

The PSW stated that they forgot to close the door. A Registered Practical Nurse (RPN) acknowledged the door should have been closed when the PSW provided the resident with personal care, to afford them with privacy.

Sources: Observations; interview with a PSW and a RPN.
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WRITTEN NOTIFICATION: Infection prevention and control program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

A) The licensee has failed to ensure that the IPAC Standard for Long-Term Care Homes, dated April 2022, was implemented, related to resident hand hygiene.

Rationale and Summary
The IPAC Standard for Long-Term Care homes, indicated under section 10.4 that the home's hand hygiene program was to include (h) support for residents to perform hand hygiene prior to receiving meals.

The lunch meal was observed on a resident home area. Signage was posted outside the dining room that directed staff to assist the residents with hand hygiene using hand sanitizer or hand wipes before and after meals. A PSW assisted three residents with hand hygiene using hand wipes. No other residents were provided with support to perform hand hygiene prior to the meal.

The following day, the lunch meal was again observed on the same resident home area. No residents were provided with support to perform hand hygiene prior to meal service. Two PSWs acknowledged that they did not assist any residents with hand hygiene prior to the meal service, and another PSW reported that some residents used hand sanitizer in the hallway prior to entering the dining room, but

this was not observed by the Inspector immediately prior to meal service.

The IPAC lead acknowledged that staff were required to provide support for residents to perform hand hygiene as they were entering the dining room using wipes or hand sanitizer, and that on both occasions, staff should have assisted the residents.

Failing to provide support to residents to complete hand hygiene prior to meal service put the residents at risk of contracting an infection.

Sources: IPAC Standard for Long-Term Care Homes, dated April 2022; dining observations; interview with PSWs and the IPAC lead.
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B) The licensee has failed to ensure that the IPAC Standard for Long-Term Care Homes, dated April 2022, was implemented, related to signage for additional precautions.

Rationale and Summary
The IPAC Standard for Long-Term Care homes, indicated under section 9.1 that additional precautions shall include (e) point-of-care signage indicating that enhanced IPAC control measures were in place.

During a tour of the home, a yellow bag of PPE was observed on the door of a resident's room and on the door of a shared resident room, but there was no signage that indicated additional precautions were required.

The IPAC lead acknowledged that the residents in the observed rooms required contact precautions and that signage should have been posted. They stated appropriate signage was put in place the next day.

Failure to post signage indicating that contact precautions were required may have increased the risk of transmission of infections.

Sources: Observations; interview with the IPAC lead.
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