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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Hamilton, ON, L8P 4Y7
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Original Public Report

Report Issue Date: February 20, 2024	
Inspection Number: 2024-1458-0001	
Inspection Type: Critical Incident	
Licensee: St. Joseph's Health System	
Long Term Care Home and City: St. Joseph's Villa, Dundas, Dundas	
Lead Inspector Parminder Ghuman (706988)	**Inspector Digital Signature** Parminder Ghuman Digitally signed by Parminder Ghuman Date: 2024.03.06 11:11:00 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): February 1-2, 5-8 & 12, 2024.

The following intake(s) were inspected:

- Intake: #00104047 - Critical Incident (CI) #2975-000072-23 - ARI - COVID - Outbreak declared on 12DEC23 - Finalized 15JAN24 - Primrose Lane/Trillium Lane/Rose Garden/Cedar Grove/Tulip Garden.
- Intake: #00105122 – CI #2975-000075-23 - ARI - Influenza A - Outbreak declared 27DEC23 – Finalized 10JAN24 – Pine Grove.
- Intake: #00107035 – CI #2975-000012-24 - Enteric - Outbreak declared 19JAN24 - Finalized 31JAN24 - Willow Grove/Oak Grove/Pine Grove.
- Intake: #00107283 – CI #2975-000013-24 - Enteric - Outbreak declared 22JAN24 - Finalized 06FEB24 - Lilac Garden/Tulip Garden.

- Intake: #00104591 – CI #2975-000073-23- Fall of resident resulting in acute subdural hemorrhage and now palliative.

The following intake(s) were completed:

- Intake: #00106610 – CI #2975-000007-24 - Fall of resident resulting in subdural hemorrhage.
- Intake: #00105766 – CI #2975-000003-24- Fall of resident resulting in multiple injuries and dx of delirium.

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

Infection Prevention and Control
Falls Prevention and Management

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 (10)

Infection prevention and control program

s. 102 (10) The licensee shall ensure that the information gathered under subsection (9) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. O. Reg. 246/22, s. 102 (10).

The licensee has failed to ensure that the information gathered under subsection (9) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks.

Rationale and Summary

The home's current Infection Prevention and Control (IPAC) leads did not review and analyze the gathered information on a monthly basis to detect trends, for the purpose of reducing the incidence of infection and outbreaks. During the audio recorded interview conducted on an identified date with IPAC leads, they acknowledged that both of them were new in their role and they were developing the program. They have not reviewed and analyzed the information gathered at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks.

Not reviewing and analyzing the gathered data to detect trends for the purpose of reducing the incidence of infection and outbreaks puts the residents at risk for managing infections and keeping the residents safe.

Sources: Interview with the IPAC leads Interview with DOC of the home.

[706988]