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
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Public Report

Report Issue Date: January 30, 2025

Inspection Number: 2025-1030-0001

Inspection Type:
Complaint
Critical Incident

Licensee: Dover Cliffs Operating Inc.

Long Term Care Home and City: Dover Cliffs, Port Dover

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 23, 27-30, 2025

The following intake(s) were inspected:

- Intake: #00131806 - Critical Incident #1056-000018-24- related to fall prevention and management.
- Intake: #00137213 - A concern regarding Infection Prevention and Control.

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 (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 implement the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, dated April 2022, as issued by the Director. Specifically, staff failed to wear personal protective equipment (PPE) when entering a resident's room with additional precautions, as required by section 9.1(d): Additional Precautions.

On a specific date, a staff member was observed in a resident's room with additional precautions but did not wear PPE while providing care. The staff member subsequently exited the room to put on the required PPE. This failure to properly use PPE increased the risk of spreading infections.

Sources: Observation of staff providing care to the resident, review of additional precaution signage, and interviews with the staff and IPAC manager.

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (15) 2.

Infection prevention and control program

s. 102 (15) Subject to subsection (16), every licensee of a long-term care home shall ensure that the infection prevention and control lead designated under this section works regularly in that position on site at the home for the following amount of time per week:

2. In a home with a licensed bed capacity of more than 69 beds but less than 200 beds, at least 26.25 hours per week.

The licensee failed to ensure that the home's Infection Prevention and Control (IPAC) Lead worked the required hours per week in their position on site.

According to Section 102(15), 2 of Ontario Regulation 246/22, a home with a licensed bed capacity of more than 69 but less than 200 beds must have a designated IPAC Lead working at least 26.25 hours per week in their position on-site. The home met the bed capacity requirement and was obligated to adhere to this stipulation.

The IPAC Manager confirmed that they did not adhere to a set number of hours for the IPAC role and could not confirm working the required hours per week in the IPAC role. This may have left gaps in the home's IPAC program, potentially putting residents at risk.

Sources: Interviews with the IPAC manager and Executive Director.