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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: May 1, 2024
Inspection Number: 2024-1081-0002
Inspection Type: Critical Incident
Licensee: CVH (No. 8) LP by its general partner, Southbridge Care Homes (a limited partnership, by its general partner, Southbridge Health Care GP Inc.)
Long Term Care Home and City: Errinrung Long Term Care Home, Thornbury

Lead Inspector	**Inspector Digital Signature**
Josee Snelgrove (674)	Josee Snelgrove Digitally signed by Josee Snelgrove Date: 2024.05.01 11:43:53 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 23 - 25, 2024

The following intake(s) were inspected:

- Intake: #00110537 - related to a Disease Outbreak
- Intake: #00112279 - related to Falls Prevention

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.

Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

The license has failed to immediately report an Influenza A outbreak to the Director.

Rationale and Summary:

On March 2, 2024, Public Health declared an Influenza A outbreak at the home.

The Director was notified of the outbreak status on March 4, 2024 instead of March 2, 2024, when the outbreak was declared.

The DOC acknowledged that the Director was not immediately informed about the outbreak as required.

Failure to immediately report the outbreak to the Director increased the risk of delayed monitoring of the home's outbreak situation.

Sources: CI report, interviews with the IPAC Lead and the DOC.
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