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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: February 15, 2023
Inspection Number: 2023-1547-0003
Inspection Type: Critical Incident System
Licensee: City of Toronto
Long Term Care Home and City: Fudger House, Toronto

Lead Inspector	**Inspector Digital Signature**
Kim Lee (741072)	Kim Lee Digitally signed by Kim Lee Date: 2023.02.16 10:31:18 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 9-10, 13-14, 2023

The following intake(s) were inspected:
- Intake #00008128 (CIS: M524-000013-22) – Related to falls

The following intakes were completed in the Critical Incident System (CIS) inspection:
- Intake #00005246 (CIS: M524-000012-22), intake #00011639 (CIS: M524-000015-22) – Related to falls

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

Infection Prevention and Control
Safe and Secure Home
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #01 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (8)

The licensee has failed to ensure that a screener participated in the implementation of the IPAC program.

Rationale and Summary

When entering the long-term care home (LTCH), a visitor was not asked to complete COVID screening by any staff. There was no signage posted indicating that visitors were required to complete COVID screening prior to entry. The visitor did not engage in any COVID screening and was allowed to enter the home.

The screener stated that all visitors were required to complete COVID screening prior to being allowed to enter the LTCH. The screener stated that they were to screen all visitors, however they had missed screening the visitor.

The Administrator stated that all visitors were required to complete active COVID screening upon entry. The IPAC Lead stated that the screener would have been expected to screen the visitor prior to entry into the LTCH. The IPAC Lead stated that all visitors were required to complete active COVID screening because it was the first line of defense in preventing COVID transmission to residents.

The LTCH's most recent COVID guidance document stated that visitors were required to actively engage in screening for COVID prior to entry as protocol.

The LTCH was not recently or currently in outbreak. Failing to screen visitors for COVID hampered the LTCH's infection control efforts and put residents at moderate risk for exposure to COVID.

Sources: observations of screening practices, interviews with staff, LTCH's most recent COVID Guidance Update

[741072]