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
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Original Public Report

Report Issue Date: April 8, 2024
Inspection Number: 2024-1547-0001
Inspection Type: Critical Incident
Licensee: City of Toronto
Long Term Care Home and City: Fudger House, Toronto

Lead Inspector	**Inspector Digital Signature**
Goldie Acai (741521)	Goldie Acai Digitally signed by Goldie Acai Date: 2024.05.01 09:22:28 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): March 6, 7, 11, 2024

The following intake(s) were inspected:

- Intakes #00104599 and #00109751 were related to outbreaks.

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

Infection Prevention and Control

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 (7) 11.
Infection prevention and control program
s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:
11. Ensuring that there is in place a hand hygiene program in accordance with any standard or protocol issued by the Director under subsection (2) which includes, at a minimum, access to hand hygiene agents at point-of-care. O. Reg. 246/22, s. 102 (7).

The licensee had failed to ensure that the infection prevention and control lead (IPAC lead) carried out their responsibilities related to the hand hygiene program.

The IPAC lead had failed to ensure that that there was in place a hand hygiene program in accordance with the "Infection Prevention and Control (IPAC) Standard for Long Term Care Homes April 2022" (IPAC Standard). Specifically, the IPAC lead failed to ensure that the hand hygiene program was performed at a minimum, during the four moments as was required under the IPAC Standard.

Rationale and Summary
On March 6, 2024, a staff member was observed in a unit in outbreak, entering and exiting two different resident rooms without performing hand hygiene. The staff member stated they should have performed hand hygiene to prevent the risk of disease transmission, but confirmed they did not. The staff member confirmed that hand hygiene should have been performed during the four moments for hand hygiene.

Failure to perform hand hygiene increased the risk for disease transmission.

Sources: Observations of staff member; interview with a staff member and the IPAC Lead; a review of Infection Prevention and Control (IPAC) Standard for Long-Term Care Home, revised September 2023.
[741521]

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 (11) (a)
Infection prevention and control program
s. 102 (11) The licensee shall ensure that there are in place,
(a) an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts; and

The licensee had failed to ensure that there was in place an outbreak management system for controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure during active outbreaks within the home, staff working on units deemed by public health to be in outbreak, remain within that unit for their shift.

Specifically, staff did not comply with the "Outbreak Management" policy, dated January 1, 2024, detailing cohorting measures included in the licensee's Infection Prevention and Control Program.

Rationale and Summary
A staff member, was observed on March 6, 2024, providing care to a resident during a meal service on a unit declared to be in outbreak. Later that day, the same staff member was observed sitting in a communal area. The home's Infection Control policy 'Outbreak Management', states 'residents and staff should be restricted to their own units.'

The IPAC Lead and a second staff member both confirmed that all staff working on units where outbreaks were declared were provided with multiple forms of communication to notify them of the outbreak. Additionally, staff members were also provided with designated spaces for various uses within that unit for the duration of the outbreak to promote staying within their units. The IPAC Lead and the second staff member both confirmed staff were required to remain on their designated units during an outbreak to minimize the risk of disease transmission.

Failure to comply with the outbreak management policy and ensuring staff working on units in outbreak remain on that unit during their assigned shifts increased the risk of disease transmission.

Sources: Interviews with the IPAC Lead and second staff member; observations of the first staff member; and record review of the homes Infection Control policy 'Outbreak Management' IC-0402-01, revised January 1, 2024.
[741521]

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 (11) (b)
Infection prevention and control program
s. 102 (11) The licensee shall ensure that there are in place,
(b) a written plan for responding to infectious disease outbreaks. O. Reg. 246/22, s. 102 (11).

The licensee has failed to ensure their outbreak management policy was implemented when an Influenza A outbreak was declared.

In accordance with O Reg. 246/22 s. 11 (1) (b) the licensee was required to ensure there was a written plan for responding to infectious disease outbreaks and must be complied with.

Specifically, staff members did not comply with the home's policy "Outbreak Management", dated January 01, 2024 which was included in the home's Infection Prevention and Control Program.

Rationale and Summary
On March 6, 2024, a station containing supplies for resident use to assist with hand hygiene and facial cleaning post meal service was set up with a pair of tongs left bedside a cooler to access the towels within. A staff member was observed exiting the dining area on a unit in outbreak, pushing a resident in a wheelchair and stopped at the cleaning station. The staff member then used their hands to remove a towel from the clean cooler without performing hand hygiene or use of the tongs and provided care to the resident using these items.

On March 11, 2024, a second staff member was observed on a different unit in outbreak, post meal service pushing a resident in their wheelchair to the cleaning station. The second staff member reached into the cooler without performing hand hygiene to obtain a towel and provided care to the resident using these items. Tongs were observed next to the cooler but were not used during this observation.

The IPAC Lead and two staff members stated above confirmed tongs should have been used to retrieve towels from the cooler, and hand hygiene should have been performed before and after providing care to their residents. The staff members stated there was an increased risk of infection transmission if proper procedures and protocols were not followed.

Staff failure to follow the home's policies and procedures for hand hygiene increases risk for disease transmission.

Sources: Observations of meal services on two separate units, and of two staff members; interview with staff the two staff members, and the IPAC Lead; a review of Infection Prevention and Control (IPAC) Standard for Long-Term Care Home, revised September 2023.
[741521]

WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #004 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 licensee failed to ensure that the Director was immediately informed, in as much detail as was possible in the circumstances of an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act in the home, followed by the report.

Rationale and Summary
On December 18, 2023, the home was declared in an outbreak by the local public health unit. A staff member received the confirmation of this outbreak via a telephone call, then notified management right away. However, the home's management failed to report the outbreak immediately to the Director, instead, the report was made the following afternoon. The staff member confirmed an immediate report should have been made as soon as the outbreak was declared using the after-hours reporting line.

Failure to immediately report an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act in the home could increase the risk of a delayed follow-up.

Sources: Interviews with the IPAC Lead and the staff member; and record review of CI: M524-000017-23, located on LTCHomes.net.
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