Ontario

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Inspection Report Under the
Fixing Long-Term Care Act, 2021

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: September 27, 2024
Inspection Number: 2024-1222-0003
Inspection Type: Critical Incident
Licensee: Kingsway Nursing Homes Limited
Long Term Care Home and City: Kingsway Lodge Nursing Home, St Marys

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 16, 2024
The inspection occurred offsite on the following date(s): September 26, 2024

The following intake(s) were inspected:

- Intake #00124295/ Critical Incident System # 2726-000006-24 related to COVID Outbreak

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 (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 any standard or protocol issued by the Director with respect to infection prevention and control (IPAC).

Rationale and Summary
During inspection observation, two staff members did not perform hand hygiene after clearing soiled utensils before supporting other residents with meals. The staff were apologetic when interviewed.

There was risk of infection transmission between residents when staff did not perform hand hygiene between supporting different residents.

Sources: Observations and staff interview.

WRITTEN NOTIFICATION: CMOH and MOH

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 272
CMOH and MOH
s. 272. Every licensee of a long-term care home shall ensure that all applicable directives, orders, guidance, advice or recommendations issued by the Chief Medical Officer of Health or a medical officer of health appointed under the Health Protection and Promotion Act are followed in the home.

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The Licensee failed to ensure that Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings issued by the Ministry of Health Effective: April 2024 was followed in the home. In accordance with these recommendations the Licensee was required to ensure that Alcohol-based hand rubs (ABHR) must not be expired.

Rationale and Summary
During inspection an ABHR was observed to be expired.

The IPAC Lead acknowledged it was the expectation that the expired ABHR be replaced.

There was risk to residents, staff, and visitors of potential transmission of micro-organisms when the home used expired ABHR product.

Sources: observations and interview with IPAC lead.