Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 3, 2022	2022_944480_0002	014242-21	Critical Incident System

Licensee/Titulaire de permis

City of Hamilton
28 James Street North 4th Floor Hamilton ON L8R 2K1

Long-Term Care Home/Foyer de soins de longue durée

Macassa Lodge
701 Upper Sherman Avenue Hamilton ON L8V 3M7

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JENNIFER ALLEN (706480)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 14, 15, 16, 18, 22, 2022.

The following intake was completed in this Critical Incident System (CIS) inspection:
Log #: 014242-21, related to falls management.

During the course of the inspection, the inspector(s) spoke with the Infection Control Practitioner, Nurse Managers, Public Health Inspector for the City of Hamilton, Infection Prevention and Control (IPAC) Outbreak Team Manager for the City of Hamilton, Registered Nurses (RN), Registered Practical Nurses (RPN), Housekeepers, and Personal Support Workers (PSWs).

During the course of the inspection, the inspector observed residents, their home areas, dining room observation, resident and staff interactions, and reviewed clinical health records, relevant home policies and procedures, and other pertinent documents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The Licensee has failed to ensure that the home was a safe and secure environment for its residents when staff did not wear the required Personal Protective Equipment (PPE) when providing direct care or interacting with suspected, probable, or confirmed cases of COVID-19.

As per Directive #5, as an interim precaution in light of the uncertainty around the mechanisms of transmission of the COVID-19 Omicron variant of concern (B.1.1.529), required precautions for all health care workers providing direct care to or interacting with a suspected, probable (i.e. placed in precautions as high risk contact, in an outbreak zone of the facility or recently transferred from a facility in outbreak) or confirmed cases of COVID-19 wore a fit-tested, seal-checked N95 respirator (or approved equivalent), eye protection (goggles or face shield), gown and gloves.

A staff member was observed not donning the required PPE when entering a suspected COVID-19 resident room on droplet contact isolation precautions. The staff did not don eye protection before entering the room. The staff, stated they were not aware of the requirement to wear eye protection when entering a resident's room that was on droplet contact precautions for suspected COVID-19.

The home’s Routine Practices & Additional Precautions Policy, stated that staff were to use eye protection in conjunction with a N95 mask when entering a resident's room on droplet/contact isolation precautions.

Interview with a Public Health Inspector, explained that any staff entering a droplet precaution isolation room must wear eye protection.

Staff failing to don the required PPE when entering a room on droplet and contact precautions for suspected COVID-19 may have increased the risk of resident exposure to infectious organisms.

Sources: Lunch observations; COVID-19 Directive #5 (Issued December 17, 2021, effective date: December 22, 2021); Routine Practices & Additional Precautions Policy (Last updated: February 7, 2022); Interview with Public Health Inspector and other staff. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that a hand hygiene program was in place in accordance with the Ontario Evidence-Based Practice (EBP) hand hygiene (HH) program, “Just Clean Your Hands” (JCYH) related to staff assisting residents with HH before and after meals.

During a dining room meal observation, it was observed that residents were not offered or provided with hand hygiene when exiting the dining room after lunch. A staff member pushed a resident in an assistive device out of the dinning room without offering and providing hand hygiene. Two other residents were portered out of the dining room by staff without being offered or provided hand hygiene, and one resident was escorted out of the dining room by a staff without being offered or provided hand hygiene. A staff member, stated the staff did not generally clean the residents' hands after meals.

Upon review of the homes’ Routine Practices & Additional Precautions policy, the policy is missing the component of hand hygiene for the residents after meals and snacks. The Infection Control Practitioner acknowledged that hand hygiene for residents after meals and snacks is absent from the policy and will be added on the next revision.

Failure to have a hand hygiene program in place in accordance with EBPs presented a risk to the residents related to the possible ingestion of disease-causing organisms that may have been on their hands.

Sources: Observations of dining room; Routine Practices & Additional Precautions Policy (Last updated: February 7, 2022) and “Just Clean Your Hands” program resources (Effective September 2009); interviews with the Infection Control Practitioner and other staff. [s. 229. (9)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9)., to be implemented voluntarily.

Issued on this 4th day of March, 2022

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.