

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: January 15, 2024	
Inspection Number: 2024-1016-0001	
Inspection Type: Critical Incident	
Licensee: CVH (No. 2) 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: Maitland Manor, Goderich	
Lead Inspector Janis Shkilnyk (706119)	Inspector Digital Signature
Additional Inspector(s)	

INSPECTION SUMMARY

<p>The inspection occurred onsite on the following date(s): January 10-12, 2024</p> <p>The following intake(s) were inspected:</p> <ul style="list-style-type: none"> • Intake: #00099968 - related to an infectious disease outbreak
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The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control

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INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC # remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (iii)

Housekeeping

s. 93 (2) As part of the organized program of housekeeping under clause 19 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,

(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

(iii) contact surfaces;

The licensee has failed to ensure that all chemical cleaning agents and disinfectants used for cleaning high touch surfaces were appropriately labelled.

Rationale and Summary

Public Health Ontario (PHO) Provincial Infectious Diseases Advisory Committee (PIDAC), best practices for environmental cleaning for prevention and control of infections in all health care settings, 3rd edition, revision April 2018, recommended all chemical cleaning agents and disinfectants should be appropriately labelled.

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It was observed that there were two bottles of clear liquid unlabeled in a housekeeping cart. Staff stated that the bottles contained disinfectant for cleaning and that the labels would not adhere. The Environmental Services Manager stated they were aware that the labels did not adhere to the bottles and that staff were to ask for a new label when it had come off.

On January 10 and 11, 2024, it was observed that all bottles of the disinfectant were labelled in the housekeeping cart.

Sources:

Observations of housekeeping cart, Public Health Ontario (PHO) Provincial Infectious Diseases Advisory Committee (PIDAC), best practices for environmental cleaning for prevention and control of infections in all health care settings, 3rd edition, revision April 2018, interviews with staff

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Date Remedy Implemented: January 10, 2024

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 (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

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prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the standard issued by the Director with respect to Infection Prevention and Control (IPAC), was implemented. Specifically, they failed to ensure staff wore the appropriate Personal Protective Equipment (PPE) when providing care to residents with additional precautions.

According to O. Reg. 246/22, s. 102 (2) (b), the licensee was required to implement any standard or protocol issued by the Director with respect to IPAC.

The IPAC Standard for Long Term Care Homes, revised September 2023, stated that the licensee shall ensure that routine practices and additional precautions are followed in the IPAC program. Section 9.1(f) Additional Precautions at a minimum, documented PPE requirements including appropriate selection application, removal and disposal by staff.

A resident was on additional precautions as they were positive for an infectious disease. Their care plan documented contact precautions for the resident and staff were to wear a mask, gown and gloves when providing direct care to the resident.

Staff was observed immediately after providing direct care to the resident. Staff were not wearing all required PPE.

Staff stated that they had not worn all required PPE.

The IPAC Lead stated they would expect staff to wear a mask, gown and gloves when providing direct care to a resident on additional precautions.

Failure to don the appropriate PPE for additional precautions when caring for the resident may have increased the potential risk for spread of infectious disease pathogens.

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Sources:

Observation, interviews with staff, review of a resident's clinical record, IPAC
Standard for Long Term Care Homes, revised September 2023

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