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

London District
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London, ON, N6A 5R2
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Original Public Report

Report Issue Date: February 21, 2023
Inspection Number: 2023-1151-0002
Inspection Type: Complaint Critical Incident System
Licensee: Meadow Park (London) Inc.
Long Term Care Home and City: Meadow Park (London), London

Lead Inspector	**Inspector Digital Signature**
Ina Reynolds (524)	Ina Reynolds Digitally signed by Ina Reynolds Date: 2023.02.21 14:39:31 -05'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred on the following date(s):
February 14, 15 and 16, 2023.

The following intake(s) were inspected:

- Intake #00006013 [CI #2643-000006-22] related to responsive behaviours
- Intake #00016789 [CI #2643-000013-22] related to the breakdown of a major system
- Intake #00011789 for a complaint related to Infection Prevention and Control and resident care concerns.

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

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Safe and Secure Home
Responsive Behaviours

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 (8)

The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control (IPAC) program.

Rationale and Summary:
A) A resident's room had additional precautions signs and a Donning and Doffing Personal Protective Equipment (PPE) direction signs posted outside their door. A Personal Support Worker (PSW) was observed going into the resident's room to offer the resident comfort support and meal assistance. Staff did not don Personal Protective Equipment (PPE) outside the resident's room at the care cart that provided the PPE prior to entry. Upon exiting the resident's space or room, the PSW did not sanitize their hands or change their mask. When asked what the expectation was regarding donning and doffing PPE, the PSW said that "I suppose I should have".

The resident's electronic clinical records in Point Click Care documented that the resident was on precautionary isolation.

The Administrator acknowledged it was the expectation that all staff follow the designated precautions signage to use the appropriate PPE.

B) It was observed that no gowns were available in the PPE care cart located outside a resident's room. The resident was on specific precautionary isolation. The IPAC Standard and Public Health Ontario guidelines had recommended that PPE was available and accessible to staff for routine practices and additional precautions.

The Administrator acknowledged that gowns were to be available in the PPE care cart. Not following the IPAC program placed the residents and staff at risk for contracting an infection.

Sources: Observations, resident's clinical records, and staff interviews.
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