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

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Original Public Report

Report Issue Date: September 13, 2024
Inspection Number: 2024-1118-0002
Inspection Type: Critical Incident
Licensee: Niagara Health System
Long Term Care Home and City: Niagara Health System, Welland Hospital Site, Extended Care Unit, Welland

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): August 29-30, September 3-5, 2024

The following intake(s) were inspected in this Critical Incident (CI) inspection:

- Intake: #00110938/CI #2607-000005-24 - was related to resident care and support services.
- Intake: #00111966/CI #2607-000007-24 - was related to fall prevention and management.
- Intake: #00114712/CI #2607-000009-24 and Intake: #00117235/CI #2607-000010-24 - were related to infection prevention and control.

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

Resident Care and Support Services
Infection Prevention and Control
Falls Prevention and Management

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).

A) The licensee has failed to implement the standard or protocol issued by the Director with respect to infection prevention and control.

The Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, revised September 2023, section 9.1 (d), indicated that at minimum routine practices should include proper use of PPE, including appropriate selection, application, removal, and disposal;

Rationale and Summary
During an observation, a direct care staff was observed donning Personal Protective Equipment (PPE) in an incorrect sequence before providing direct care to the resident on additional precautions. Direct care staff acknowledged during an interview that they did not follow the right sequence of wearing PPE before providing direct care to the resident.

Failing to wear PPE in an appropriate sequence may increase the risk of transmission of infectious microorganisms to the resident.

Sources: Interview with staff, observations, IPAC standard for Long Term Care Homes -routine practices and additional precautions (revised in September 2023), PPE Donning and Doffing policy (revised February 2023)

B) The licensee has failed to implement the standard or protocol issued by the Director with respect to infection prevention and control related to resident hand hygiene.

The Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, revised September 2023, section 10.2 (c), indicated the hand hygiene program for residents shall include: c) Assistance to residents to perform hand hygiene before meals and snacks;

Rationale and Summary
The inspector observed the lunch meal service in the dining area. During the observation, a staff member served a lunch meal to the resident. Staff did not offer or assist the resident with hand hygiene before and after serving the meal to the resident.

Staff acknowledged during an interview that they did not offer or assist the resident with hand hygiene before and after serving the meal to the resident.

By not performing resident hand hygiene before serving food and drinks it may increase the risk of transmission of microorganisms to the resident.

Sources: Interview with staff, observations, and Hand Hygiene policy for residents

(revised February 2023)

C) The licensee has failed to implement the standard or protocol issued by the Director with respect to infection prevention and control.

The Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, revised September 2023, section 4.3, indicated that 'following the resolution of an outbreak, the OMT and the interdisciplinary IPAC team conduct a debrief session to assess IPAC practices that were effective and ineffective in the management of the outbreak. A summary of findings shall be created that makes recommendations to the licensee for improvements to outbreak management practices'.

Rationale and Summary
The home was in an acute respiratory outbreak and there were no documented records of an outbreak debrief session or summary of outbreak findings after the outbreak was declared over.

Home's IPAC lead indicated that there was an outbreak debrief session that was conducted after the outbreak was declared over by the Outbreak Management Team (OMT). The IPAC lead acknowledged that there were no documented records of the outbreak debrief session and outbreak summary findings.

The IPAC Lead failed to ensure that responsibilities related to outbreak preparedness and management were carried out. Specifically, the IPAC lead did not ensure that following an outbreak, the post outbreak debrief summary was documented.

By not complying with the IPAC standard's outbreak preparedness and management strategies, the home may not have properly mitigated the risk of

outbreak re-occurrence.

Sources: Interview with IPAC lead and record review of the IPAC Standard (revised September 2023)

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.

The licensee has failed to ensure that staff followed IPAC measures as part of the recommendations issued by the Chief Medical Officer of Health (CMOH).
The Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings (effective April 2024) indicate that 'Alcohol-based hand rubs must not be expired'.

Rationale and Summary
The inspector observed an expired alcohol-based handrub by a resident's room entrance.

Environmental Services Staff confirmed that the alcohol-based handrub had expired (expired in October 2023).

Failing to replace the expired alcohol-based handrub may increase the risk of

transmission of infectious organisms to the resident.

Sources: Interview with environmental services staff, observations, and Recommendations for Outbreak Prevention and Control in Institutions and Congregate Living Settings (effective April 2024)