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

**Central West District**
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

# Original Public Report

**Report Issue Date:** October 10, 2024

**Inspection Number:** 2024-1579-0002

**Inspection Type:**
Critical Incident

**Licensee:** Corporation of the County of Grey

**Long Term Care Home and City:** Rockwood Terrace Home for the Aged, Durham

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 23-27, 2024 and October 3-4, 2024

The following intake(s) were inspected:

- Intake: #00122866 - related to financial abuse.
- Intake: #00124689 - related to COVID-19 Outbreak.
- Intake: #00125100 - related to COVID-19 Outbreak.
- Intake: #00127173 - related to unexpected death of resident.

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

Infection Prevention and Control
Prevention of Abuse and Neglect
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).

The licensee has failed to ensure that the infection prevention and control (IPAC) standard issued by the Director was followed by staff.

Specifically, additional requirement under 9.1 the IPAC Standard states that the licensee shall ensure that hand hygiene, including, but not limited to, at the four moments of hand hygiene before initial resident/resident environment contact; before any aseptic procedure; after body fluid exposure risk, and after resident/resident environment contact) were followed.

**Rationale and Summary**
A Personal Support Worker (PSW) was observed wearing gloves in the dining room while assisting two residents.

The Infection Prevention and Control (IPAC) Lead stated the PSW should not have worn gloves while assisting residents in the dining room.

**Sources:** Dining room observations; Interviews with PSW and IPAC Lead.