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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002
torontodistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: January 24, 2023	
Inspection Number: 2023-1215-0002	
Inspection Type: Critical Incident System	
Licensee: St. Clair O'Connor Community Inc.	
Long Term Care Home and City: St. Clair O'Connor Community Nursing Home, East York	
Lead Inspector Fiona Wong (740849)	**Inspector Digital Signature** Fiona Hoi Kwan Wong-Dip Digitally signed by Fiona Hoi Kwan Wong-Dip Date: 2023.01.25 11:10:06 -05'00'
Additional Inspector(s) Jack Shi (760) was present during this inspection to conduct observations.	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 17-19, 2023

The following intake(s) were inspected:

- Intake: #00015728 – Critical Incident System (CIS): 2719-000011-22 - related to falls prevention and management

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

Falls Prevention and Management
Infection Prevention and Control

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 #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O.Reg. 246/22, s. 102 (7) 11.

The licensee has failed to ensure that the infection prevention and control (IPAC) lead carried out their responsibilities related to the hand hygiene program in accordance with "IPAC Standard for Long-Term Care Homes, April 2022" (IPAC Standard).

Specifically, the IPAC Lead failed to ensure that the hand hygiene program included access to 70-90% Alcohol-Based Hand Rub (ABHR) as was required by Additional Requirement 10.1 under the IPAC Standard. The IPAC Lead failed to remove expired ABHR that was in use in the home.

Rationale and Summary
On January 17, 2023, two bottles of expired ABHR were located on resident dining tables. A Registered Practical Nurse (RPN) was notified of the observation, and the expired bottles were removed. On the same day, another bottle of expired ABHR was located at the entrance of a resident home area. The IPAC Lead was notified of the observation, and the expired bottle was not observed in a follow-up observation on January 18, 2023.

The IPAC Lead indicated that the use of expired ABHR was not in line with the manufacturer's recommendation. The Director of Care (DOC) stated that expired hand sanitizers are ineffective against microorganisms and would impact the alcohol percentage of the product.

No other expired ABHR were observed during the remainder of the inspection.

There was low risk to residents as there were non-expired ABHR available for use.

Sources: Inspector #740849's observations, Interview with the IPAC Lead and the DOC.

[740849]

Date Remedy Implemented: January 18, 2023

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan.

Rationale and Summary
The resident was at risk for falls. The resident was assessed to require a specified intervention to decrease their risk of falling. The resident's plan of care indicated that they also required a falls prevention intervention when in a certain location.

On a specified day, the resident had a fall. A Personal Support Worker (PSW) and a Registered Nurse (RN) stated they were unaware of the above-mentioned interventions in the resident's plan of care. The RN confirmed that a falls prevention intervention was not used on the day of the incident.

The Physiotherapist (PT) stated that the specified intervention should have been implemented at the time of the incident. The DOC acknowledged that a falls prevention intervention should have been in place as indicated in the resident's plan of care.

Failure to ensure that the care set out in the plan of care was provided to the resident could have contributed to further injuries that the resident sustained after their fall.

Sources: The resident's clinical records, interviews with a PSW, an RN, the PT, and the DOC.

[740849]