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

Original Public Report

Report Issue Date: June 19, 2023	
Inspection Number: 2023-1215-0004	
Inspection Type: Follow up	
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: 2023.06.20 10:35:35 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 15-16, 2023

The following intake(s) were inspected:

- Intake: #00085253 - Follow-up #: 1 - related to transferring and positioning techniques.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #001 from Inspection #2023-1215-0003 related to O. Reg. 246/22, s. 40 inspected by Fiona Wong (740849)

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Binding on Licensees

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that a policy directive that applied to long-term care homes, was complied with.

In accordance with the Minister's Directive: COVID-19 response measures for long-term care homes, licensees were required to ensure that the masking requirements set out in the "COVID-19 Guidance Document for Long-Term Care Homes in Ontario", were followed.

The guidance document required that all staff, students and volunteers wear a medical mask for the entire duration of their shift indoors regardless of their immunization status. All staff must comply with masking requirements at all times, even when they are not delivering direct patient care, including in administrative areas.

Rationale and Summary
An administrative staff was observed interacting with a resident while wearing their medical mask under their chin. On another day, the administrative staff was observed working at their desk wearing their medical mask under their chin again. The administrative staff stated that they interact with residents, staff, and family daily.

A housekeeper was observed wearing their medical mask under their nose within a resident home area.

The administrative staff and the housekeeper acknowledged that they were not wearing their medical masks appropriately.

The IPAC Lead stated that all staff must wear medical masks properly while working indoors. They indicated that the administrative staff and the housekeeper did not properly don their medical mask during their shifts.

Staff's failure to appropriately don medical mask during their shifts increased the risk of infection

transmission to residents and other staff.

Sources: inspector's observations, interviews with the administrative staff, the housekeeper, and the IPAC Lead, Minister's Directive: COVID-19 response measure for long-term care homes, COVID-19 guidance document for long-term care homes in Ontario.

[740849]

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