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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Original Public Report

Report Issue Date: October 4, 2024
Inspection Number: 2024-1159-0003
Inspection Type: Critical Incident
Licensee: QCC Corp.
Long Term Care Home and City: Watford Quality Care Centre, Watford

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 2, 2024
The inspection occurred offsite on the following date(s): October 3, 2024
The following intake(s) were inspected:

- Intake: #00120699 - 2652-000009-24 - ARI-COVID – Outbreak

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

Infection Prevention and Control

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 a standard issued by the Director with respect to infection prevention and control was implemented. Specifically, the licensee failed to assist residents to perform hand hygiene before and after each meal service, in accordance with Additional Requirement 10.2 (c) under the "Infection Prevention and Control Standard for Long Term Care Homes" (IPAC Standard), April 2022, last revised September 2023.

Rationale and Summary

On October 2, 2024, inspector observed the entire lunch service in the main dining room noting each resident's table had a bag of wet wipes and a bottle of alcohol-based hand rub (ABHR) was seen attached to the wall near the kitchen. During the observation residents were not offered or observed using the wet wipes prior to the lunch meal service nor were residents offered assistance to use the wet wipes or provided with alcohol-based hand rub (ABHR) after the meal service.

During an interview with resident #001, on October 2, 2024, who confirmed they were not offered hand hygiene prior to eating their breakfast on October 2, 2024, nor after their meal. Resident #001 stated that staff rarely provide or offer hand hygiene prior to meals or after meals.

RPN #105, confirmed during an interview on October 2, 2024, that the expectation for all staff were to provide or assist all residents with hand hygiene prior to all meals and after all meals daily.

Failing to provide residents with hand hygiene before and after each meal service put the residents at low risk for a potential exposure to infectious organisms.

Sources
Observation of the main dining room, staff and resident interviews.

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