

**Ministry of Long-Term Care** Long-Term Care Operations Division Long-Term Care Inspections Branch London Service Area Office 130 Dufferin Ave, 4<sup>th</sup> Floor London ON N6A 5R2 Telephone: 1-800-663-3775 LondonSAO.moh@ontario.ca

# **Original Public Report**

Report Issue Date	April 27, 2022						
Inspection Number	2022_1526_0001						
Inspection Type							
☐ Critical Incident Syste	em   Complaint		□ Director Order Follow-up				
☐ Proactive Inspection	□ SAO Initiated		☐ Post-occupancy				
☐ Other			<u>_</u>				
Licensee The Leamington United Mennonite Home and Apartments Long-Term Care Home and City Leamington Mennonite Home Long-Term Care Residence Leamington, ON Lead Inspector							
Debra Churcher #670							
Additional Inspector(s Julie D'Alessandro #739	,						

# **INSPECTION SUMMARY**

The inspection occurred on the following date(s): April 25 and 26, 2022.

The following intake(s) were inspected:

- #001764-22 Follow up inspection related to order #001 from Inspection #2022 953563 0001 related to training requirements.
- #001764-22 Follow up inspection related to order #002 from Inspection #2022\_953563\_0001 related to IPAC.

#### **Previously Issued Compliance Order(s)**

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

Legislative Reference		Inspection #	Order #	Inspector (ID) who complied the order
O. Reg. 79/10	r. 221. (1)	2022_953563_0001	#001	#739
O. Reg. 79/10	r. 229. (4)	2022_953563_0001	#002	#670

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

- Infection Prevention and Control (IPAC)
- Staffing, Training and Care Standards



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#### **INSPECTION RESULTS**

During the course of this inspection, the inspector(s) made relevant observations, reviewed records and conducted interviews, as applicable. There were findings of non-compliance.

### WRITTEN NOTIFICATION [INFECTION PREVENTION AND CONTROL LEAD]

## NC#001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

### Non-Compliance with: O. Reg. 246/22 s.102 (15) 2.

The Licensee has failed to ensure that subject to subsection (16), every licensee of a long-term care home shall ensure that the infection prevention and control lead designated under this section works regularly in that position on site at the home for the following amount of time per week: In a home with a licensed bed capacity of more than 69 beds but less than 200 beds, at least 26.25 hours per week.

#### **Rationale and Summary**

FLTCA, 2021, s. 23. (4) states "Except as provided for in the regulations, every licensee of a long-term care home shall ensure that the home has an infection prevention and control lead whose primary responsibility is the home's infection prevention and control program."

During an interview with Infection Prevention and Control Lead (IPAC Lead) #111 they stated that they would often get redeployed to work as a staff nurse on their scheduled IPAC days and that the weekly IPAC hours they worked would vary from zero to two days per week.

During an interview with the Director of Care (DOC) #103 they stated that the IPAC Lead was not working 26.5 hours per week in that role and that the home had not been scheduling the IPAC Lead 26.5 hours per week in that role.

Review of the homes schedule showed that IPAC Lead #111 had been scheduled for IPAC duties for 16 hours the week of April 11, 2022, through April 16, 2022, and for 24 hours the week of April 17, 2022, through April 23, 2022. IPAC duties were scheduled for eight hour shifts on April 12, 14, 19, 20, and 21, 2022.

**Sources:** Interviews with IPAC Lead #111 and DOC #103 and review of the homes schedule. [#670]