

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

London District

130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: October 22, 2024

Inspection Number: 2024-1448-0003

Inspection Type:

Critical Incident

Licensee: The Women's Christian Association of London

Long Term Care Home and City: McCormick Home, London

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 15 - 18, 2024

The following intake(s) were inspected:

- Intake: #00121887 - related to a fall
- Intake: #00129257 - related to an outbreak

The following intake(s) were also completed:

- Intake: #00120578 - related to an outbreak

Inspection Manager was also present during the inspection.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

London District

130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

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

Non-compliance with: O. Reg. 246/22, s. 102 (11) (b)

Infection prevention and control program

s. 102 (11) The licensee shall ensure that there are in place,

(b) a written plan for responding to infectious disease outbreaks. O. Reg. 246/22, s. 102 (11).

The licensee has failed to comply with their written plan for responding to infectious diseases.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure there is a written plan for responding to infectious diseases, and this plan must be complied with.

Specifically, multiple staff did not comply with the outbreak management plan by not wearing proper eye protection while on the outbreak unit.

Rationale and Summary

As a part of the home's outbreak management plan, staff were to wear N95 masks and eye protection. Multiple staff were observed not wearing eye protection or inappropriate eye protection.

Not following the outbreak management plan by not wearing proper eye protection increased the risk of staff becoming infected while working on the outbreak unit.

Sources: IPAC observations, record reviews and staff interviews

COMPLIANCE ORDER CO #001 Infection prevention and control program

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

London District

130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

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 inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

- 1) Retrain staff members on the proper removal of personal protective equipment (PPE) when exiting a resident's room on droplet/contact precautions. The home is to keep a record of this training until this order is complied.
- 2) Complete weekly audits with on-the-spot feedback of staff removing PPE when exiting a resident's room on additional precautions. A minimum of three moments of PPE removal must be audited per week. The audits must be completed weekly until this order is complied with. Records of the audits must be kept until this order is complied with, and must include: the name of the auditor, the role of the person being audited, the location of the audit, date/time of the audit, and on-the-spot feedback for improper removal of PPE.

Grounds

The licensee has failed to ensure the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, dated April 2022, issued by the Director, was implemented.

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

London District

130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

The licensee has failed to ensure staff appropriately removed their PPE upon exiting resident rooms under droplet/contact precautions, as was required by section 9.1 (f): Additional Precautions, within the IPAC Standard.

Rationale and Summary

A staff member was observed exiting a resident's room, which had droplet/contact precautions implemented. The staff member did not remove their gloves, mask, and eye protection and did not complete hand hygiene. The staff member stated they were not aware that they needed to remove all their PPE or the correct sequence to do so.

Another staff member was observed exiting two different residents' rooms, which had droplet/contact precautions implemented. Upon exiting multiple residents' rooms, the staff member did not complete hand hygiene prior to removing their mask and eye protection. The staff member did not meet the expectations for doffing because they were required by the home to complete hand hygiene prior to removing PPE from their face to prevent self-contamination.

The first staff member not removing all their PPE after exiting a resident room increased the risk of the spread of the virus. The second staff member missing hand hygiene while removing their PPE increased the risk of self-contamination.

Sources: Observations and staff interviews

This order must be complied with by November 22, 2024

COMPLIANCE ORDER CO #002 Infection prevention and control program

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

London District

130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Infection prevention and control program

s. 102 (9) The licensee shall ensure that on every shift,

(b) the symptoms are recorded and that immediate action is taken to reduce transmission and isolate residents and place them in cohorts as required. O. Reg. 246/22, s. 102 (9).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1. Retrain staff on the local Public Health Unit's guidelines for managing residents with respiratory symptoms. The home will keep a record of this retraining until this order is complied with.

Grounds

The licensee has failed to ensure symptoms of a potentially infectious disease were recorded for a resident, and that residents were isolated as required.

Rationale and Summary

Following the declaration of an outbreak by the local Public Health unit two residents were put into isolation but their symptoms were not recorded and they were removed from isolation.

The home was to follow the local Public Health Unit's guidelines for managing residents with respiratory symptoms. These guidelines said that if a resident had two or more new or unusual respiratory symptoms, they should be isolated, tested, and kept in isolation based on the test results.

Not following the local public health guidelines for isolation and removing the residents from isolation increased the risk of spreading a potentially infectious disease.

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

London District

130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Sources:

Observations, progress notes, Local Public Health Unit respiratory symptom guidelines, and staff interviews

This order must be complied with by

November 22, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

London District

130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

- (a) the portions of the order or AMP in respect of which the review is requested;
- (b) any submissions that the licensee wishes the Director to consider; and
- (c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director

c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:

- (a) registered mail, is deemed to be made on the fifth day after the day of mailing
- (b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
- (c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

London District

130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:

- (a) An order made by the Director under sections 155 to 159 of the Act.
- (b) An AMP issued by the Director under section 158 of the Act.
- (c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board

Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director

c/o Appeals Coordinator

Ministry of Long-Term Care

Long-Term Care Operations Division
Long-Term Care Inspections Branch

London District

130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.