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

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Original Public Report

Report Issue Date: December 4, 2024
Inspection Number: 2024-1448-0004
Inspection Type: Critical Incident Follow up
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): November 26 - 29, 2024

The following intake(s) were inspected:

- Intake: #00125125/ Critical Incident (CI) #2965-000025-24, related to a resident's health event with transfer to hospital
- Intake: #00125950/ CI #2965-000026-24, related to use of personal assistance service device (PASD)
- Intake: #00129978/ CI #2965-000031-24, related to a fall
- Intake: #00130060/ CI #2024-1448-0003, follow up related to infection prevention and control (IPAC)
- Intake: #00130061/ CI #2024-1448-0003, follow up related to IPAC program
- Intake: #00130395/ CI #2965-000033-24, related to resident health event
- Intake: #00133138/ CI #2965-000034-24, related to outbreak

The following intakes were also completed:

- Intake: #00128687/ CIS #2965-000028-24 related to a fall

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1448-0003 related to O. Reg. 246/22, s. 102 (2) (b)
Order #002 from Inspection #2024-1448-0003 related to O. Reg. 246/22, s. 102 (9) (b)

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Falls Prevention and Management
Restraints/Personal Assistance Services Devices (PASD) Management

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

1) The licensee has failed to ensure that a staff member appropriately removed their personal protective equipment (PPE) upon exiting a resident's room under additional precautions, as required by the IPAC Standard.

Rationale and Summary
On November 27, 2024, a staff member exited a resident's room with droplet/contact precautions, removing their PPE and not following the posted PPE removal instructions.

2) The licensee failed to ensure that a staff member completed hand hygiene after resident/resident environment contact, as required the IPAC Standard.

Rationale and Summary
On November 27, 2024, a staff member exited a resident's room with droplet/contact precautions without completing hand hygiene after removing some PPE. The staff then interacted with others without performing hand hygiene.

The resident's area had a declared outbreak, increasing the risk of spreading infection when proper PPE removal and hand hygiene protocols were not followed.

Sources: Observation, review of PPE signage, outbreak line list, and staff interviews.

WRITTEN NOTIFICATION: Medication management system

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 123 (3) (a)
Medication management system
s. 123 (3) The written policies and protocols must be,
(a) developed, implemented, evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and

The Licensee failed to ensure the implementation of written policies and protocols for the medication management system.

Rationale and Summary:
A Critical Incident System (CIS) Report was received on October 25, 2024, regarding a resident's health event with transfer to hospital.

An Registered Practical Nurse (RPN) noted a low blood sugar level but did not follow up with necessary treatment or documentation until alerted by a Personal Support Worker (PSW). The resident then required treatment and transfer to hospital.

The Medication Administration Record (MAR) showed medication was withheld due to low blood sugar, but no treatment was provided according to the home's medication policy, which requires specific treatment.

Failure to follow the policy posed a risk of health complications for the resident.

Sources: Record review, Medication policy review; staff interviews.