

Ministry of Long-Term Care

Long-Term Care Operations Division

Long-Term Care Inspections Branch

Inspection Report Under the Fixing Long-Term Care Act, 2021

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

Original Public Report

Report Issue Date: November 20, 2023

Inspection Number: 2023-1047-0007

Inspection Type:

Critical Incident

Licensee: Caressant-Care Nursing and Retirement Homes Limited

Long Term Care Home and City: The Maples Home for Seniors, Tavistock

Lead Inspector Henry Otoo (000753) Inspector Digital Signature

Additional Inspector(s)

INSPECTION SUMMARY

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

The following intake(s) were inspected:

 Intake #00099980/ CI#2093-000008-23 related to COVID-19 Outbreak declared on19th October 2023 inspection.

The following Inspection Protocols were used during this inspection:

Infection Prevention and Control



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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)

The licensee has failed to implement any standard or protocol issued by the Director with respect to Infection Prevention and Control (IPAC).

Rationale and Summary

The Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes states the following under ADDITIONAL REQUIREMENT UNDER THE STANDARD: **9.1** The licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program. At minimum Routine Practices shall include e) Use of controls, including: **i.** Environmental controls, including but not limited to cleaning.

During inspection on November 15, 2023, the inspector observed two staff members use a transfer lift in a resident's room and after left it in the hallway without cleaning and disinfection. The inspector asked one of the staff members why the equipment was not cleaned and disinfected after use. The staff member said they forgot to clean and disinfect the equipment, but the normal practice is to clean and disinfect the equipment after use. The same staff had earlier used another lift and not cleaned and disinfected after use, which they confirmed through interview. The DOC confirmed during interview that staff are to clean and disinfect shared equipment after each use. By failing to clean and disinfect the equipment between resident use, there was risk of transferring disease-causing microorganism from one resident to the other or from staff to resident, or from staff to staff.

Sources: Observations and staff interviews. [000753]