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

Central West District
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Waterloo, ON, N2V 1K8
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Original Public Report

Report Issue Date: May 22, 2024

Inspection Number: 2024-1114-0002

Inspection Type:
Critical Incident
Follow up

Licensee: Caressant-Care Nursing and Retirement Homes Limited

Long Term Care Home and City: Caressant Care Fergus Nursing Home, Fergus

Lead Inspector	**Inspector Digital Signature**
Nuzhat Uddin (532)	Nuzhat J Uddin Digitally signed by Nuzhat J Uddin Date: 2024.06.04 08:53:12 -04'00'

Additional Inspector(s)
Craig Michie (000690)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 6,-10, 14 and 15, 2024.

The following intake(s) were inspected:
- Intake: #00110759 was related to follow-up
- Intake: #00112564 was related to infection prevention and control
- Intake: #00112754 and #00112849 were related to alleged neglect.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2024-1114-0001 related to FLTCA, 2021, s. 3 (1) 16. inspected by Nuzhat Uddin (532)

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Residents' Rights and Choices

INSPECTION RESULTS

WRITTEN NOTIFICATION: continence care and bowel management

NC # 001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (g)
Continence care and bowel management
s. 56 (2) Every licensee of a long-term care home shall ensure that residents who require continence care products have sufficient changes to remain clean, dry and comfortable.

The licensee has failed to ensure that a resident who required continence care products have sufficient changes to remain clean, dry and comfortable.

On a specified date, a resident's continence care product and clothing were saturated with urine and feces.

Record review indicated that the resident was checked once and were not changed again as required in their plan of care.

Resident Assessment Instrument (RAI) Coordinator stated that the staff acknowledged that they did not change the resident a second time.

There was potential risk of harm to the resident when they were left in feces and urine and were not checked or changed.

Sources:
Record review, the home's investigation notes and interview with staff.

[532]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #002 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). In accordance with the IPAC Standard last revised September 2023, the section titled Additional Requirements 4.3 states: the licensee shall ensure that following the resolution of an outbreak, the OMT and the interdisciplinary IPAC team conduct a debrief session to assess IPAC practices that were effective and ineffective in the management of the outbreak. A summary of findings shall be created that makes recommendations to the licensee

for improvements to outbreak management practices.

On March 28, 2024, the home went into a respiratory outbreak on a specified date. The respiratory outbreak was declared over on April 7, 2024.

There was no meeting minutes or communication available related to summary of findings, lessons learned, or any changes or recommendations made to the Licensee for improvements to the outbreak management practices.

The Director of Care (DOC) and the RAI Coordinator both acknowledged that the Outbreak management Team (OMT) and the interdisciplinary Infection prevention and control (IPAC) team did not conduct a debrief session to assess IPAC practices that were effective and ineffective in the management of the outbreak.

Failure of the home to conduct the debrief sessions to discuss and identify processes that worked well and areas for improvement, placed the residents and the staff at risk of further spread of infections

Sources: Record review and interviews with DOC and RAI Coordinator.
[000690]

WRITTEN NOTIFICATION: Reports re critical incidents

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.
Reports re critical incidents
s. 115 (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under

subsection (5):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

On March 28, 2024, public health declared a confirmed RSV outbreak. The Licensee reported the outbreak to the Director on March 29, 2024.

The Director of Care (DOC) stated that the confirmed outbreak declared by public health should have been reported immediately, and confirmed it was reported a day late.

Failure of the home to immediately report the confirmed RSV outbreak to the Director may have delayed the Director in responding to the incident.

Sources: Record review and interview with Director of Care.
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