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
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: August 15, 2024
Inspection Number: 2024-1114-0004
Inspection Type: Complaint Critical Incident
Licensee: Caressant-Care Nursing and Retirement Homes Limited
Long Term Care Home and City: Caressant Care Fergus Nursing Home, Fergus

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 29-31, and August 1-2, 6-9, 2024

The following intake(s) were inspected:

- Intake: #00119172 - [IL-0127641-CW / IL-0128192-CW] - Complaint related to care received in the home
- Intake: #00121568 - [IL-0128809-CW] - Complaint related to abuse
- Intake: #00119568 - [IL-0127809-AH /2603-000029-24] - Related to responsive behaviours
- Intake: #00121439 - [IL-0128690-AH / 2603-000031-24] - Related to abuse

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours

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INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary; or

The licensee has failed to ensure that a resident's care plan was reviewed and revised when the care set out in the plan was no longer necessary.

Rationale and Summary
A resident's care plan stated that the resident required specific falls interventions to be implemented.

During an observation period, the falls prevention and management strategies were not in use.

Staff stated that the resident did not use the falls preventions and management strategies.

The Director of Care (DOC) acknowledged that the resident refused the fall interventions and that the resident's care plan should have been updated.

By failing to update the plan of care, there was potential for the resident to receive discontinued interventions.

Sources: Observations, clinical record for a resident, interviews with staff.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible; and

The licensee has failed to ensure that strategies for managing a resident's responsive behaviours were implemented.

Rationale and Summary
A resident's care plan had specific strategies to manage the resident's responsive behaviours.

During altercations with other residents, the resident's care plan was not followed.

During an observation period, the strategies for managing the resident's responsive behaviours were not in place.

Failure to implement the plan of care a resident, put other residents at risk for

potential injury.

Sources: Observations, resident clinical records, interviews with staff

WRITTEN NOTIFICATION: Infection prevention and control program

NC #003 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).

1) The licensee failed to implement the IPAC Standard, last revised September 2023, when staff did not complete HH at the four moments of hand hygiene (HH).

In accordance with the Additional Requirements in the IPAC Standard section 9.1 (b) staff are expected to perform HH, including, but not limited to, at the four moments of hand hygiene.

Rationale and Summary
It was observed that a staff member did not perform HH after resident/resident environment contact, and reentering resident's room.

The Infection Prevention and Control (IPAC) Lead stated that the 1:1 staff should have performed HH upon leaving and entering the resident's room.

When staff did not complete HH, there was a risk of transmission of infectious agents.

Sources: Observations, Interview with IPAC Lead.

2) The licensee failed to implement the IPAC Standard, last revised September 2023, when staff did not don the appropriate personal protective equipment (PPE).

In accordance with the Additional Requirements in the IPAC Standard section 9.1 (d) staff are expected to utilize appropriate PPE to ensure additional precautions are followed.

Rationale and Summary
It was observed that a staff member was only wearing a face mask while in a resident's room. At the time, there was a droplet/contact precautions sign on the door stating visitors of the room required mask and eye protection, gloves, and a gown.

The IPAC Lead stated that the staff was not wearing the appropriate PPE while inside a resident's room.

When staff did not wear the appropriate PPE, there was a risk of transmission of infectious agents.

Sources: Observations, Interview with IPAC Lead.