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: November 1, 2024
Inspection Number: 2024-1114-0005
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 dates: October 22-24, 28-30, 2024

The following intake(s) were inspected:

- Intake: #00122034 - 2603-000035-24: Respiratory Outbreak.
- Intake: #00127239 : Complainant related to resident care.

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

Resident Care and Support Services
Infection Prevention and Control
Safe and Secure Home

INSPECTION RESULTS

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WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care
s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(c) clear directions to staff and others who provide direct care to the resident; and

The licensee failed to ensure that the plan of care for a resident set out clear directions for staff who provide direct care to the resident related to meal service and continence care.

Rationale and Summary:
The resident's care plan had contradictory information related to continence care and meal service.

Staff stated that the some of the interventions listed in the residents care plan related to continence care and meal service were no longer in place and no longer followed by staff.

The RAI Coordinator acknowledged that the care plan for the resident was not updated as required to include the correct interventions.

By failing to update the plan of care and by having contradictory interventions listed, there was potential for the resident to receive the incorrect interventions.

Sources: clinical records for resident, interviews with staff.