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: October 28, 2022	
Inspection Number: 2022-1184-0001	
Inspection Type: Complaint Critical Incident System	
Licensee: Carveth Nursing Home Limited	
Long Term Care Home and City: Carveth Care Centre, Gananoque	
Lead Inspector Wendy Brown (602)	**Inspector Digital Signature** Wendy K Brown Digitally signed by Wendy K Brown Date: 2022.10.28 11:58:16 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 4 - 7 & 12, 2022

The following intake(s) were inspected:

- Intake: #00001306, #00002101 & #00002103 - Complaint regarding sufficient staffing and air temperature in the home.
- Intake: #00005130 - Complaint regarding improper care of a resident.
- Intake: #00007401 - Complaint regarding sufficient staffing infection prevention and control protocols and dining.
- Intake: #00006939/CIS #2683-000006-22 - regarding a fall with injury requiring transfer to hospital.
- Intake: #00003996/CIS #2683-000006-22 - regarding a fall with injury requiring transfer to hospital.

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

Resident Care and Support Services
Falls Prevention and Management
Infection Prevention and Control

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting and Complaints

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 115 (4)

The licensee failed to ensure the Director was informed no later than one business day after a resident was admitted to hospital for injuries resulting in a significant change in health status.

Rationale and summary
A resident was admitted to hospital for post fall fractures. A critical incident report was submitted to the Director by the Director of Care (DOC) six days later.

Sources: Critical Incident System report, resident progress notes, care plan and interviews with DOC and other staff.

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 (7) 11.

The licensee failed to follow Infection Prevention and Control (IPAC) evidenced based practices by not assisting residents to perform hand hygiene before and after meals.

Rational and summary
Public Health Ontario's Best Practices for Hand Hygiene in All Health Care Settings indicates that staff should assist residents to perform hand hygiene before and after meals. Lunch hour observations in the main dining area revealed three residents were not assisted with hand hygiene prior to attending the dining area. This observation was shared with the IPAC lead who indicated they would send out a reminder message to staff. Neglecting hand hygiene can increases the risk of virus transmission among residents and staff.

Sources: Public Health Ontario - Best Practices for Hand Hygiene in All Health Care Settings, 4th

Edition (April 2014), dining area observations and interviews with the DOC, IPAC lead and other staff.