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 24, 2023	
Inspection Number: 2023-1272-0004	
Inspection Type: Complaint Critical Incident System	
Licensee: Collingwood Nursing Home Limited	
Long Term Care Home and City: Collingwood Nursing Home, Collingwood	
Lead Inspector Gabriella Del Principe (741734)	**Inspector Digital Signature** Gabriella Del Principe Digitally signed by Gabriella Del Principe Date: 2023.06.05 11:20:41 -04'00'

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 26-27, 2023 and May 1-5, 9-12, 2023.

The following intake was completed in this complaint inspection:
• Intake #00086218 was related to skin and wound care.

The following intakes were completed in this Critical Incident (CI) inspection:
• Intake #00019763 was related to alleged abuse.
• Intake #00014166 was related to falls prevention and management.

The following intakes were completed in this inspection: Intake #00008051, #00008109, #00009156, and #00016902 were related to falls prevention and management.

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: DUTY TO PROTECT

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee failed to protect a resident from abuse by a co-resident.

Rationale and Summary

A resident acted inappropriately towards their co-resident, which resulted in the co-resident to fall and sustain an injury.

The resident had a history of aggression and their plan of care identified interventions to prevent a recurrence. On the morning of the incident, the resident was not provided a medication that was prescribed for them, to help manage their aggression.

Failure to follow the resident's responsive behaviour interventions and protect the co-resident from abuse, could have had a greater impact to the resident's quality of life.

Sources: Critical Incident; Residents' clinical health records; Interview with Assistant Director of Care (ADOC), and Director of Care (DOC). [741734]

WRITTEN NOTIFICATION: IMPLEMENTATION OF PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (4) (b)

The licensee failed to ensure that a nutritional intervention was included in a resident's plan of care and implemented.

Rationale and Summary

In January 2023, it was recommended that a resident receive a nutritional supplement twice a day, instead of once a day, for wound management support.

A review of the resident's clinical health records indicated that the recommendation was not appropriately communicated amongst staff members at the time and was not included in the resident's plan of care until May 2023.

Failure to ensure that all aspects of care are integrated delayed the resident from receiving a nutritional intervention that could have supported their nutritional care needs.

Sources: Resident's clinical health records; Interviews with Registered Nurse (RN), and DOC. [741734]