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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Original Public Report

Report Issue Date: September 27, 2024
Inspection Number: 2024-1018-0001
Inspection Type: District Initiated
Licensee: ATK Care Inc.
Long Term Care Home and City: The Fordwich Village Nursing Home, Fordwich

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 17-20, 2024

The following intake(s) were inspected:

- Intake: #00126614 - District Initiated Inspection

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

Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Medication Management
Residents' and Family Councils
Infection Prevention and Control
Reporting and Complaints
Falls Prevention and Management

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 (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 has failed to ensure that there was a written plan of care for a resident that sets out clear directions to staff and others who provide direct care to the resident.

Rationale and Summary
A resident had a fall, which resulted in injury. Staff stated the resident was not to have access to an item. A review of the resident's plan of care identified that it did not set out clear directions to staff regarding access to that item.

Failure to provide staff with clear directions caused the resident an injury.

Sources: record review of a resident's clinical records and a Critical Incident report and interview with staff.

WRITTEN NOTIFICATION: Plan of Care

NC #002 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 when a resident was reassessed, the plan of care was reviewed and revised when the resident's care needs changed.

Rationale and Summary
A resident fell, which resulted in an injury. The resident was reassessed but their plan of care was not reviewed and revised. Staff stated that the resident's care needs changed and the plan of care was not reviewed and revised until inspectors asked them.

Failure to review and revise the resident's plan of care put the resident at risk of harm.

Sources: record review of a resident's clinical records and interview with staff.

WRITTEN NOTIFICATION: Dining and Snack Service

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 5.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
5. Food and fluids being served at a temperature that is both safe and palatable to the residents.

The licensee has failed to ensure that staff followed the home's Temperatures of

Food at Point of Service policy, while serving food to residents.

As per O. Reg. 246/22, s. 11 (1) (b), the licensee shall ensure that where the Act or Regulations required the licensee of a long-term care home to have, institute, or otherwise put in place any policy, the licensee was required to ensure that the policy was complied with.

The home's Temperatures of Food at Point of Service policy stated that staff are to take the holding temperature of foods just before serving.

Rationale and Summary
On two days, staff did not take the temperatures of the food in the dining room prior to serving the food to the residents at a mealtime.

By failing to follow the home's Temperatures of Food at Point of Service policy, staff were unable to ensure that the food being served was both safe and palatable for the residents.

Sources: observation of a meal, interviews with staff, and record review of the home's Point of Service Food Temperature Records and the home's Temperatures of Food at Point of Service policy, last reviewed November, 2023.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #004 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).

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) Standard issued by the Director was implemented.

According to the IPAC Standard for Long-Term Care Homes (LTCHs) dated April 2022, section 7.3 (b) directs the licensee to ensure that audits are performed at least quarterly to ensure that all staff can perform the IPAC Skills required for their role.

Rationale and Summary
From April to June 2024, no audits were completed for two departments outside of hand hygiene to ensure they could perform all IPAC skills required for their role.

By failing to follow the IPAC Standard and not completing audits for all staff within the home, to ensure they could perform the required IPAC skills for their role, there was risk of transmission of infectious agents.

Sources: interviews with staff and record review of the Hand Hygiene and Personal Protective Equipment (PPE) audits completed from April to June 2024, and the IPAC Standard, issued April 2022.