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

Ottawa District
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Original Public Report

Report Issue Date: July 21, 2023	
Inspection Number: 2023-1240-0003	
Inspection Type: Complaint Critical Incident System	
Licensee: Genesis Gardens Inc.	
Long Term Care Home and City: Foyer St-Viateur Nursing Home, Limoges	
Lead Inspector Julienne NgoNloga (502)	**Inspector Digital Signature** Julienne Ngo Nloga Digitally signed by Julienne Ngo Nloga Date: 2023.07.26 09:52:02 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 6, 7, 10, 11, 2023

The following intake(s) were inspected:
Complaint
· Intake: #00022701 related to required programs.

Critical Incident System Report (CIS)
· Intake: #00086440 (CIS #000003-23) related to a fall with injury.
· Intake #00088670 (CIS #2746-000004-23) related to skin and wound.

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

Skin and Wound Prevention and Management
Infection Prevention and Control
Responsive Behaviours
Recreational and Social Activities
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: General Requirements for Programs

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 3.

The licensee has failed to ensure that the following was complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation.

Specifically, the licensee must evaluate and updated the required programs, at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Rationale and Summary:
During the inspection two management staff members provided the policies and procedures for four organized programs that have not been revised in the past few years.

Both management staff members acknowledged that those Programs had not been evaluated and updated in the past few years, but they have been tasked to revise all their programs.

As such, the home had not evaluated and updated four organized programs annually in accordance with evidence based practices and or prevailing.

Sources: Four organized Programs. Interview with staff members.
[502]

WRITTEN NOTIFICATION: Recreational and Social Activity

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 71 (2) (b)

The licensee has failed to ensure that the program includes the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during evenings.

Rationale and Summary

Review of the Activity Calendar for the month of July 2023, the interviews with two staff members indicated the recreational and social activities were not scheduled in the evening.

As such, the residents were not engaged in any recreational and social activity in the evening increasing the risk of responsive behaviours.

Sources: July Activity Calendar. Interviews with staff members.
[502]

WRITTEN NOTIFICATION: Infection Prevention and Control

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)

The licensee has failed to implement any standard or protocol issued by the Director with respect to infection prevention and control (IPAC).

In accordance with additional requirement under the standard 9.1 (d) the licensee has failed to ensure that proper use of Personal Protective Equipment (PPE) was followed in the IPAC program, including appropriate selection, application, removal, and disposal.

Rationale and Summary
In July 2023, the Inspector observed two staff members wearing gloves. Both staff members preformed different care tasks during a snack service while assisting the residents with the snack. Both staff members had not changed their gloves between various care tasks. This was brought to a management

staff member's attention.

Two management staff members indicated that not changing gloves was a reoccurrence concerns with staff members. They have been providing ongoing education on the importance of not wearing gloves and performing hand hygiene when feeding a resident.

As such, the residents were exposed to cross-contamination when the staff did not apply, remove and dispose of PPE between various tasks while provision of care to residents.

Sources: Observation and staff members interviews
[502]