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
centralwestdistrict.mltc@ontario.ca

Amended Public Report (A1)

Report Issue Date: December 8, 2022

Inspection Number: 2022-1601-0001

Inspection Type:
Critical Incident System

Licensee: Corporation of the County of Grey

Long Term Care Home and City: Grey Gables Home for the Aged, Markdale

Inspector who Amended	**Inspector who Amended Digital Signature**
Robert Spizzirri (705751)	Robert Spizzirri Digitally signed by Robert Spizzirri Date: 2022.12.08 14:12:18 -05'00'

Additional Inspector(s)
April Racpan (218)

AMENDED INSPECTION REPORT SUMMARY

This public inspection report has been amended, removing a non-compliance remedied, due to additional information provided by the home. The Critical Incident System inspection, inspection #2022-1601-0001 was completed on November 17, 2022.

MODIFIED INSPECTION REPORT SUMMARY

This licensee inspection report has been modified to reflect it is a public report correct the inspection summary. The Critical Incident System inspection, inspection #2022-1601-0001 was completed on November 17, 2022.

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 14-17, 2022

The following intake(s) were inspected:

- Intake: #00006478 related to falls prevention and management

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection prevention and control program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 23 (5)

The licensee has failed to ensure that the infection prevention and control (IPAC) lead possess the qualifications provided in the regulations.

Rationale and Summary

The licensee was required to designate an IPAC Lead who had the education and experience outlined in the regulations.

The IPAC Lead said that they did not have the education and experience required.

The DOC confirmed that the IPAC lead did not have the required education and experience.

Designating an IPAC lead who does not have the required qualifications puts the IPAC program at increased risk of being unsuccessful.

Sources: Interview with IPAC Lead and DOC.

[705751]

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 (15) 1.

The licensee has failed to ensure that the infection prevention and control lead works regularly in that position for at least 17.5 hours per week.

Rationale and Summary

The home designated an Infection Prevention and Control (IPAC) lead who was regularly scheduled 7.5 hours weekly to specifically focus on IPAC.

The IPAC Lead said that 7.5 hours was not enough time for them to complete their responsibilities.

The DOC acknowledged that the IPAC Lead is required to work 17.5 hours; however, said the home was unable to schedule those hours due to other operational needs.

Not scheduling the IPAC lead for the required hours increased the risk of essential tasks and responsibilities being missed.

Sources: Observation on November 15, 2022, Monthly Schedule, Interview with IPAC Lead and DOC.

[705751]