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: November 27, 2024

Inspection Number: 2024-1601-0002

Inspection Type:
Critical Incident

Licensee: Corporation of the County of Grey

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

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): November 13, 14, 19, 20 and 22, 2024.

The following intake(s) were inspected:

- Intake: #00129884 related to a COVID-19 outbreak declared on Oct 20, 2024.
- Intake: #00130370 related to an allegation of staff to resident abuse.

The following intakes were reviewed:

- Intake #00124370 and Intake #00130013 related to COVID-19 outbreaks.

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

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Training

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 82 (2) 3.
Training
s. 82 (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.

The licensee failed to ensure that a Personal Support Worker received training on the long-term care home's policy to promote zero tolerance of abuse and neglect of residents before they performed their responsibilities.

Rationale and Summary

A PSW said they received a one-hour orientation prior to their shift however they did not receive any training on the home's policy to promote zero tolerance of abuse and neglect of resident.

Review of the PSW's orientation checklist indicated that they were able to locate the home's Policies and Procedure binder but it did not indicate any orientation or review of the policies.

Staff not having training on the long-term care home's policy to promote zero tolerance of abuse and neglect of residents prior to performing their responsibilities may put residents at an increased risk of abuse or neglect.

Sources: interviews with PSW and Director of Care, review of Grey County PSW

Orientation Checklist for Plan A and Orientation Passport.

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 (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 Standard issued by the Director with respect to Infection Prevention and Control (IPAC), was implemented.

Rationale and Summary

According to O. Reg. 246/22, s. 102 (2) (b), the licensee is required to implement any standard or protocol issued by the Director with respect to IPAC.

The IPAC Standard for Long-Term Care Homes (LTCHs), revised in September 2023, section 9.1 indicates the licensee shall ensure that Routine Practices and Additional Precautions are followed in the IPAC program.
Additional Precautions should include at minimum additional personal protective equipment (PPE) requirements, including appropriate selection and application.

A resident was to be on precautions in addition to routine practices.

Two staff were observed coming out of the resident's room after providing direct care. One PSW shared that they did not wear a gown during direct care despite

signage posted that the resident was on precautions in addition to routine practices and that gowns and gloves were needed for direct care.

The RPN stated that staff were to wear gowns and gloves when providing direct care to the resident.

Staff not following the appropriate practices related to Additional Precautions, regarding PPE use posed a potential risk for spreading harmful microorganisms throughout the home.

Sources: observations of staff after providing direct care to the resident, Public Health Ontario-Additional Precautions signage, IPAC Standard (September 2023), review of the resident's clinical record, interview with PSW and RPN.