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

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Original Public Report

Report Issue Date: December 28, 2022	
Inspection Number: 2022-1047-0003	
Inspection Type: Complaint	
Licensee: Caressant-Care Nursing and Retirement Homes Limited	
Long Term Care Home and City: The Maples Home for Seniors, Tavistock	
Lead Inspector Christie Birch (740898)	**Inspector Digital Signature** Christie Birch Digitally signed by Christie Birch Date: 2022.12.28 09:27:22 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s): December 12 and13, 2022
The following intake(s) were inspected:

- Intake 00007847-Complainant with concerns regarding communication with the home.

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

Infection Prevention and Control
Resident Care and Support Services

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #1 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (5)

The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A concern was brought forward by the complainant in relation to the communication from the home staff for updates on the residents.

In an interview, the Executive Director acknowledged both children are Power of Attorney (POA) jointly. The Executive Director also acknowledged complainant requested to be contacted with updates in a certain method.

In an interview the Registered Nurse acknowledged to only contact the First Contact in Point Click Care for updates.
In the POA document obtained by the home, both children were named as POAs jointly.
In the progress notes, only one substitute decision-maker (SDM) was documented to be contacted when there was a change of status.
In the resident profile in Point Click Care only one child was identified as POA and the other noted as "Call as last resort only".

Sources: Interviews with Executive Director and Registered Nurse
Record Review - Progress notes, Resident profile-Contacts in Point Click Care, POA documents.
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WRITTEN NOTIFICATION: IPAC Lead

NC # 2 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg s.246/22, s. 102 (15) 1.

The Licensee has failed to ensure that the infection prevention and control lead worked regularly in that position on site at the home for at least 17.5 hours per week

Section 102 (15) 1 of the Ontario Regulation 246/22 specified a home with a licensed bed capacity of 69 or fewer, was required to have a designated infection prevention and control (IPAC) lead who worked regularly on site at the home for a minimum of 17.5 hours a week. The home had less than 69 bed capacity, and therefore met the 17.5 hours per week requirement.

The Maples, Director of Care(DOC) confirmed being both the DOC and IPAC lead and had not worked a set number of hours in the IPAC role. They could not attest that they had spent the minimum of 17.5 hours per week requirement in their IPAC Lead role.
The Executive Director confirmed that the DOC was also the IPAC lead and had not worked the required 17.5 hours per week consistently in the IPAC role.

The home not having a designated IPAC lead whose primarily responsibility was the home's IPAC program has not shown evidence of risk to residents at the time of inspection.

Sources: Interview with The Maples DOC/IPAC Lead, Interview with Executive Director

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