Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Central West Service Area Office
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Original Public Report

Report Issue Date May 9, 2022
Inspection Number 2022_1170_0001
Inspection Type
☒ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☐ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

Licensee
Caressant-Care Nursing and Retirement Homes Limited

Long-Term Care Home and City
Caressant Care Listowel Nursing Home, Listowel

Lead Inspector
April Racpan (218)

Additional Inspector(s)
Katherine Adamski (753)

Inspector Digital Signature
April Joy Tolentino
2022.05.12 09:04:21 -04'00'

INSPECTION SUMMARY

The inspection occurred on the following date(s): April 25-29 and May 2-4, 2022.

The following intake(s) were inspected:

- Intake: 001458-22 related to resident to resident abuse
- Intake: 013433-21 related to falls prevention and management

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

- Falls Prevention and Management
- Infection Prevention and Control (IPAC)
- Prevention of Abuse and Neglect
- Responsive Behaviours

INSPECTION RESULTS

WRITTEN NOTIFICATION: PREVENTION OF ABUSE AND NEGLECT

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: LTCHA, 2007, s. 19 (1).

The licensee has failed to ensure that resident #002 was protected from abuse by resident #003.

Section 2 (1) of the Ontario Regulation 79/10 defines physical abuse as the use of physical force by a resident that causes physical injury to another resident.

Rationale and Summary
A Critical Incident (CI) report was submitted to the Ministry of Long-Term Care (MLTC) related to a physical altercation between resident #002 and #003.

Resident #003 was to remain separated from resident #002 as per their plan of care.

Resident #002 was physically abused by resident #003 resulting in an injury that has healed.

Sources: CI report, the home's internal investigation records, resident #002 and #003's plans of care and kardex, progress notes, assessments, MDS, orders, risk management, interviews with Executive Director and other staff.

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WRITTEN NOTIFICATION: CMOH AND MOH

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 272.

The licensee has failed to ensure that Directive #3 was followed in the home.

Rationale and Summary
Directive #3 requires Long-Term Care Homes (LTCH) to conduct regular IPAC self-audits using the Public Health Ontario's (PHO) COVID-19: Self-Assessment Audit Tool for LTCHs and Retirement Homes. The audits were to be completed at a minimum, every two weeks when the home was not in an outbreak.

During the inspection, the home was not considered to be in an outbreak.

Audits were completed for the following areas at varying times of the week: screening, use of personal protective equipment (PPE), hand hygiene, and break rooms. The home's auditing process did not encompass all required sections within the PHO Self-Assessment Audit Tool. The frequency in which some of the audits were being completed (i.e., break rooms) were not completed at the minimum biweekly frequency.

There was a low risk of not completing the required PHO Self-Assessment Audit Tool as per Directive #3 because the home's IPAC audits did not cover all required components of the PHO tool and the audits were not completed at the minimum frequency required.

Sources: COVID-19 Directive #3 for LTCHs under the LTCHA, 2007, issued March 14, 2022, COVID-19 Guidance: LTCHs and Retirement Homes for Public Health Units Version 4 – February 3, 2022, PHO's COVID-19: Self-Assessment Audit Tool for LTCHs and Retirement Homes Published December 23, 2021, the home's auditing records, interviews with the IPAC Lead and other staff.

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WRITTEN NOTIFICATION: IPAC PROGRAM

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154(1)1

Non-compliance with: O. Reg. 246/22 s. 102 (5).

The licensee has failed to ensure that the designated IPAC Lead had education and experience in IPAC practices.

Rationale and Summary
A manager in the home was hired for a specific role and was not aware that they were also the home's IPAC Lead, until after they started working at the home. They clarified that they had no IPAC experience or education.

The manager said that actions were in process to have them enrolled in IPAC courses. They also said that discussions were held with the licensee to restructure the home's lead positions.

Sources: Listowel NH Job No. CCNRH1723, interviews with the IPAC Lead.

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WRITTEN NOTIFICATION: IPAC PROGRAM

NC #004 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 IPAC Lead worked regularly in the position on site at the home for at least 17.5 hours per week.

Rationale and Summary
The IPAC Lead clarified that since they were hired, they had not worked any hours in the IPAC Lead role because their primary focus was on the responsibilities of their other primary role. They were still in the process of orientation and had not completed any IPAC Lead tasks, such as IPAC audits. There was no coverage for the IPAC Lead role while they were in orientation.

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There was a moderate risk to resident care because the home did not have an active IPAC Lead who worked the minimum required hours, resulting in IPAC tasks not completed.

Sources: LTCH's Job Description – IPAC Lead, last reviewed January 2021, interviews with the IPAC Lead and Executive Director.

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