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: September 27, 2024
Inspection Number: 2024-1170-0002
Inspection Type: Critical Incident
Licensee: Caressant-Care Nursing and Retirement Homes Limited
Long Term Care Home and City: Caressant Care Listowel Nursing Home, Listowel

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 9 - 11, and 17 - 19, 2024

The following intake(s) were inspected:

- Intake: #00117823 - COVID outbreak on East home area
- Intake: #00120916 - Staff to resident abuse allegation

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

Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that a Personal Support Worker (PSW) reported an allegation of abuse to their supervisor immediately, leading to a delay in reporting of the incident to the Director. Pursuant to s. 154 (3), the licensee is vicariously liable for staff members failing to comply with subsection 28 (1).

Rationale & Summary

A resident disclosed an allegation of staff to resident abuse to a PSW and the PSW did not report this to anyone at the home until two days later. Due to this delayed reporting, the incident was reported late to the Ministry of Long-Term Care (MLTC).

The DOC stated that the PSW should have reported the incident to the registered staff or management of the home immediately after becoming aware of the incident.

By failing to report an allegation of abuse immediately, it delayed both the licensee and Director's ability to take action promptly.

Sources: Review of the critical incident (CI), and interview with the DOC

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 (7) 4.
Infection prevention and control program
s. 102 (7) The licensee shall ensure that the infection prevention and control lead designated under subsection (5) carries out the following responsibilities in the home:
4. Auditing of infection prevention and control practices in the home.

The licensee failed to ensure that the IPAC lead was auditing infection prevention and control practices within the home.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to implement any standard or protocol issued by the Director with respect to infection prevention and control, and ensure it is complied with.

Specifically, the IPAC lead did not complete regular audits to ensure that all staff could perform the IPAC skills required of their role, as per the Infection Prevention and Control (IPAC) Standard for Long-Term Care Homes, revised September 2023, section 7.3 (b).

Rationale & Summary

Multiple IPAC audits were reviewed during the inspection; however, the home's IPAC lead confirmed they do not have, nor complete, audits to ensure that all staff can perform the IPAC skills required for their role.

By failing to complete the IPAC audits as required by the IPAC Standard, there was risk of staff not performing their IPAC duties correctly.

Sources: Interview with the IPAC lead.