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 16, 2022	
Inspection Number: 2022-1272-0003	
Inspection Type: Complaint Critical Incident System	
Licensee: Collingwood Nursing Home Limited	
Long Term Care Home and City: Collingwood Nursing Home, Collingwood	
Lead Inspector Sharon Perry (155)	**Inspector Digital Signature** Sharon M Perry Digitally signed by Sharon M Perry Date: 2022.11.16 15:33:53 -05'00'
Additional Inspector(s) Dianne Tone (000686) was present during this inspection.	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 26-28, October 31-November 3, and November 7-8, 2022.

The following intake(s) were inspected:

- Intakes: #00001817, #00002493, #00003348, #00003720 and #00004587 related to hypoglycemic events.
- Intakes: #00002717), #00002959 and #00005118 related to incidents resulting in injury for which the resident is taken to hospital and which resulted in a significant change in the resident's health status.
- Intakes: #00012771 and #00013299 related to alleged neglect.

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

Infection Prevention and Control
Falls Prevention and Management
Medication Management
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 102 (15) 1.

The licensee failed to ensure that for a home with a licensed bed capacity of fewer than 69 beds that the infection prevention and control (IPAC) lead worked regularly in that position on site at the home for at least 17.5 hours per week.

Summary and Rational

The Director of Care/ IPAC Lead worked 37.5 hours per week with their primary role being Director of Care. They acknowledged that they were aware for a home with a licensed bed capacity of fewer than 69 beds required an IPAC lead for 17. 5 hours and that the requirement was not being met.

The home not having an IPAC Lead whose primary responsibility was the IPAC program for at least 17.5 hours per week could contribute to inadequate oversite of the provision of IPAC practices.

Sources: schedules and interviews with Ward Clerk and DOC/IPAC Lead. [155]