Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 9, 2021	2021_873602_0035	013110-21	Critical Incident System

Licensee/Titulaire de permis

Keay Nursing Homes Inc.
15 Oakwood Links Lane Grand Bend ON N0M 1T0

Long-Term Care Home/Foyer de soins de longue durée

E. J. McQuigge Lodge
38 Black Diamond Road P.O. Box 68 Cannifton ON K0K 1K0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

WENDY BROWN (602)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): October 28 & 29, 2021

The following inspection was completed:
Log #013110-21 - regarding a resident fall with injury and transfer to hospital.

During the course of the inspection, the inspector(s) spoke with Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), the Director of Care/Infection Prevention & Control (IPAC) lead, the physiotherapy assistant, and housekeeping staff.

In addition, the inspector reviewed resident health care records: including plans of care & progress notes, investigation documentation, relevant policies and procedures, and made resident care & services, and IPAC practice observations.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident.

After a resident was assisted to the toilet, the Personal Support Worker (PSW) left the bathroom and heard a loud bang; upon return the resident was found laying on the bathroom floor. An assessment was completed and the resident was transferred to hospital for assessment and repair of an injury. A review of the plan of care indicated staff were to stay with the resident during toileting.

SOURCES:
A Critical Incident report, resident's plan of care, nursing summary, progress notes and interview(s) with the Director of Care (DOC), a physiotherapy assistant and other staff. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure resident care is provided as outlined in the plan of care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The licensee failed to ensure that a hand hygiene program was in place in accordance with evidence-based practices.

Evidenced-based practice indicates that staff should assist residents to perform hand hygiene before and after meals. Infection Prevention and Control (IPAC) observations of the dining area revealed resident hands were not cleaned prior to attending or within the dining area(s). PSW staff indicated that performing hand hygiene before and after meals was not always completed; neglecting hand hygiene at this time increases the risk of virus transmission among residents and staff.

SOURCES: Public Health Ontario - Best Practices for Hand Hygiene in All Health Care Settings, 4th Edition (April 2014), IPAC Checklist, IPAC observations and interview with DOC/IPAC management lead and PSW staff. [s. 229. (9)]

Issued on this 9th day of November, 2021

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.