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

North District
159 Cedar St, Suite 403
Sudbury, ON, P3E 6A5
Telephone: (800) 663-6965

Original Public Report

Report Issue Date: July 4, 2023	
Inspection Number: 2023-1424-0002	
Inspection Type: Complaint Critical Incident System	
Licensee: Foyer Hearst - Mattice - Soins De Sante	
Long Term Care Home and City: Foyer Des Pionniers, Hearst	
Lead Inspector Sylvie Byrnes (627)	**Inspector Digital Signature** Sylvie Byrnes Digitally signed by Sylvie Byrnes Date: 2023.07.10 15:32:08 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 21-22, 2023

The following intake(s) were inspected:

- One intake related to a fall; and,
- One complaint related to a fall of a resident.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care for a resident was provided to the resident as specified in the plan.

Rationale and Summary

A resident's care plan identified the level of assistance a resident required for specific activities of daily living (ADLs). On a specific date, care was not provided to the resident as was indicated in their plan of care, which caused the resident to sustain an injury. The Director of Care (DOC) acknowledged that care was not provided as per the resident's care plan.

The resident sustained an injury which caused a change to their health status when care was not provided as indicated in their care plan.

Sources: interviews with PSWs, a Registered Nurse (RN) and DOC; Record review of a resident's care plan, home's policy titled, "The Care Plan" and a Critical incident System (CIS) report. [627]

WRITTEN NOTIFICATION: Directives by Minister

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)

The licensee has failed to ensure that every operational or policy directive that applied to the long-term care home, related to COVID-19 self-assessment audits, was complied with.

Rationale and Summary

In accordance with the Minister's Directive, "COVID-19 response measures for long-term care homes", the home was to conduct regular infection prevention and control (IPAC) self-audits at a minimum once a week when the home was in outbreak.

During a Covid-19 outbreak, an IPAC self audit was not completed for a one week period. The IPAC lead stated that they had visually completed the self-audit; however, they had not documented it.

There was no impact and low risk to the residents, at the time of the non-compliance, when the home had not completed the COVID-19 self-audit when in Covid outbreak.

Sources: Minister's Directive: COVID-19 response measures for long-term care homes; COVID-19 Guidance Document for Long-Term Care Homes in Ontario; Interviews with the IPAC Lead and DOC. [627]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (4) (d)

The licensee has failed to ensure that the local medical officer of health appointed under the Health Protection and Promotion Act or their designate was invited to the quarterly interdisciplinary IPAC team meetings.

Rationale and Summary

The DOC stated that they had not invited the medical officer of health to the quarterly IPAC team meeting as they were unaware of the requirement.

There was no harm to the residents when the medical officer of health was not invited as the medical officer of health had frequent contact with the home.

Sources: Interview with DOC. [627]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (4) (e)

The licensee had failed to ensure that the IPAC program was evaluated and updated at least annually.

Rationale and Summary

The DOC stated that they had not completed the yearly IPAC program evaluation for the year 2022.

Sources: Interview with DOC and IPAC lead. [627]

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