

Ministry of Long-Term Care

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

London District

130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: February 21, 2025
Original Report Issue Date: February 5, 2025
Inspection Number: 2025-1311-0001 (A1)
Inspection Type: Critical Incident Follow up
Licensee: Caessant-Care Nursing and Retirement Homes Limited
Long Term Care Home and City: Caessant Care Courtland, Courtland

AMENDED INSPECTION SUMMARY

This report has been amended to:
Include a statement on previously issued compliance order, CO #001 from Inspection #2024-1311-0003 related to O. Reg. 246/22, s. 102 (2) (b), which was found not to be in compliance. WN #001, WN #002, WN #003 and WN #004, were not amended, therefore the served date remains February 5, 2025.

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INSPECTION SUMMARY

The inspection occurred onsite on the following dates: January 27-29, 31, and February 3-5, 2025

The following intakes were inspected:

- Intake: #00132631 - CIS: 2826-000034-24 - Related to Infection Prevention and Control
- Intake: #00133265 - Follow-up #: 1 - CO #001/2024_1311_0003, O. Reg. 246/22 - s. 102 (2) (b), IPAC, CDD January 24, 2025.

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- Intake: #00135919 - CIS: 2826-000041-24 - Related to Infection Prevention and Control
- Intake: #00137034 - CIS: 2826-000001-25 - Related to Infection Prevention and Control

Previously Issued Compliance Order(s)

The following previously issued Compliance Order was found **NOT** to be in compliance:

Order #001 from Inspection #2024-1311-0003 related to O. Reg. 246/22, s. 102 (2) (b)

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

Medication Management
Infection Prevention and Control

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AMENDED INSPECTION RESULTS

WRITTEN NOTIFICATION: Right to quality care and self-determination

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

Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

19. Every resident has the right to,

iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

The licensee has failed to ensure that residents' personal health information, within the meaning of the Personal Health Information Protection Act, 2004, was kept confidential in accordance with that Act, when on a specified day, a staff member failed to lock a medication cart screen which displayed residents' electronic health care records, prior to leaving the medication cart unattended on 13 occasions.

Sources: Observations and interview with staff.

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WRITTEN NOTIFICATION: Licensee must comply

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

Non-compliance with: FLTCA, 2021, s. 104 (4)

Conditions of licence

s. 104 (4) Every licensee shall comply with the conditions to which the licence is subject.

CO #001 from inspection #2024-1311-0003 issued on November 28, 2024, with a compliance due date of January 24, 2025, to O. Reg. 246/22 s. 102 (2) (b) was not complied with.

The following component of the order was not complied:

2. Complete once daily audits when the home is in outbreak to ensure that high touch surfaces are cleaned and disinfected as per the home's policy and procedures for frequency and product use. Maintain a written record of the date(s) and time(s) of the audits, the name(s) of the person(s) who completed the audits, the outcome of the audits and any corrective action taken because of the audits until this order is complied.

The licensee has failed to complete once daily audits to ensure that high touch surfaces were cleaned and disinfected as per the home's policy and procedures for frequency and product use, as was required.

Sources: High Touch Surfaces Audits and interview with staff.

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An Administrative Monetary Penalty (AMP) is being issued on this written notification AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #001

Related to Written Notification NC #002

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of \$1100.00, to be paid within 30 days from the date of the invoice.

In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with an order under s. 155 of the Act.

Compliance History:

CO #001 to O. Reg. 246/22 s. 102 (2) (b) from inspection #2024-1311-0003 issued on November 28, 2024, with a compliance due date of January 24, 2025.

This is the first AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.

Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

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WRITTEN NOTIFICATION: Infection prevention and control

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

Non-compliance with: O. Reg. 246/22, s. 102 (11) (a)

Infection prevention and control program

s. 102 (11) The licensee shall ensure that there are in place,

(a) an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts; and

The licensee failed to comply with the home's Infection Prevention and Control (IPAC) Program when the reporting requirements outlined in the home's Outbreak Management Policy were not followed.

In accordance with O. Reg. 246/22, s. 11 (1) (b), the licensee is required to ensure that written policies developed for the IPAC Program are complied with.

Specifically, staff did not notify management on-call or Public Health for a suspect outbreak, as was expected as part of the home's IPAC Program.

Sources: Residents' electronic health care records, line list, Outbreak Management Policy, interviews with staff.

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WRITTEN NOTIFICATION: Security of drug supply

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 139 1.

Security of drug supply

s. 139. Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:

1. All areas where drugs are stored shall be kept locked at all times, when not in use.

The licensee has failed to ensure that steps were taken to secure the drug supply in a medication cart when the cart was not in use, when on a specified day, a staff member failed to lock the cart when not in use on 11 occasions and left a bottle of medication on the top of the cart while unattended on one occasion.

Sources: Observations and interview with staff.