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
Dec 20, 2021	2021_921769_0005	015077-21	Critical Incident System

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue Woodstock ON N4S 3V9

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

Caressant Care Fergus Nursing Home
450 Queen Street East Fergus ON N1M 2Y7

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

BRITTANY NIELSEN (705769)

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): December 8-10, 13-14, 2021.

The following intakes were completed in this Critical Incident System (CIS) inspection:

Log # 015077-21 related to an unexpected death.

Inspector Debbie Warpula (577) was present during the inspection.

During the course of the inspection, the inspector(s) spoke with the Regional Manager, Interim Director of Care (DOC), the Resident Care Coordinator (RCC), a Registered Nurse (RN), a Registered Practical Nurse (RPN), Personal Support Workers (PSWs), a Housekeeper, an Administrative Assistant, a Screener, and a resident.

The inspector observed residents and their home areas, staff Infection Prevention and Control (IPAC) practices, reviewed relevant clinical records, home policies and procedures, and the corresponding clinical incident (CI) report.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Infection Prevention and Control
Nutrition and Hydration

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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the IPAC program. Specifically, the licensee failed to implement the required resident hand hygiene best practices before receiving their snack.

As per the home's Hand Hygiene policy, hands of residents are to be cleaned before assisting with meals and snacks, which a staff member said refers to when residents receive their snack.

During the course of the inspection, multiple residents were provided their snack either in their room or in a common area and were not encouraged, reminded, or assisted to perform hand hygiene by staff before their snack.

By not implementing hand hygiene best practices for residents before their snack, there was potential risk for the spread of infectious microorganisms.

Sources: observations of snacks, the home's Hand Hygiene policy (revised September 2020), interviews with staff. [s. 229. (4)]

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 that every licensee of a long-term care home shall ensure that the infection prevention and control program required under subsection 86 (1) of the Act complies with the requirements of this section, specifically related to all staff participate in the implementation of the program, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
1. An emergency, including fire, unplanned evacuation or intake of evacuees. O. Reg. 79/10, s. 107 (1).
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).
3. A resident who is missing for three hours or more. O. Reg. 79/10, s. 107 (1).
4. Any missing resident who returns to the home with an injury or any adverse change in condition regardless of the length of time the resident was missing. O. Reg. 79/10, s. 107 (1).
5. An outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).
6. Contamination of the drinking water supply. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #001 passed away, the Director was informed of the unexpected death immediately following the incident.

The home required that the Director be informed immediately of the incident, however the incident was not reported to the Director until the following day. In an interview with staff, the staff acknowledged that the incident was not immediately reported as required.

Sources: CIS report and interview with staff. [s. 107. (1)]

Issued on this 20th day of December, 2021

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

Original report signed by the inspector.