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
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901
centralwestdistrict.mltc@ontario.ca

Amended Public Report (A1)

Report Issue Date: December 2, 2022	
Inspection Number: 2022-1114-0002	
Inspection Type: Complaint	
Licensee: Caressant-Care Nursing and Retirement Homes Limited	
Long Term Care Home and City: Caressant Care Fergus Nursing Home, Fergus	
Lead Inspector Jessica Bertrand (722374)	**Inspector Digital Signature** Jessica F Bertrand Digitally signed by Jessica F Bertrand Date: 2022.12.02 12:21:12 -05'00'
Additional Inspector(s) Kaitlyn Puklicz (000685) was present during the inspection.	

MODIFIED PUBLIC INSPECTOR REPORT SUMMARY

- This public inspection report has been revised to reflect the change of revoking a written notification of nutrition manager.
- The complaint inspection #2022-1114-0002 was completed on October 27, 2022.

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 11, 2022
October 25, 2022
October 26, 2022
October 27, 2022
October 28, 2022

The following intake was completed in this complaint inspection:

- Intake: #00008473 related to oxygen tank concerns and quality of food served.

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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901
centralwestdistrict.mltc@ontario.ca

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

Infection Prevention and Control
Food, Nutrition and Hydration
Resident Care and Support Services

INSPECTION RESULTS

WRITTEN NOTIFICATION: Infection Prevention and Control Lead

NC #01 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 23 (4)

The licensee has failed to ensure the home had an Infection Prevention and Control (IPAC) lead whose primary responsibility was the home's infection prevention and control program.

Rationale and Summary
At the start of the inspection, the Executive Director (ED) indicated the home did not have an IPAC lead, and they were waiting on corporate direction. At that time, the Director of Care (DOC) was the IPAC designate.

Later email communication during the inspection documented that a separate IPAC lead would not be hired for the home, and the Assistant Director of Care or Resident Care Coordinator (RCC) in the home would have the IPAC lead position assigned to them.

Four days after the email was received, the RCC indicated they were notified that day of their new role as IPAC lead. They stated they were not currently in the position, and they were waiting for confirmation on the reassignment of their current responsibilities. The home was not able to provide a job description for the IPAC lead role at the time of inspection.

By failing to ensure the home had an IPAC lead whose primary responsibility was the home's IPAC program, there was risk that the home would not have adequate knowledge and resources dedicated to IPAC practices that could put residents, staff and visitors at risk for disease transmission.

Sources: interviews with the ED, DOC and the RCC, email communication, and Caressant Care Fergus Management Team – Main Duties.

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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901
centralwestdistrict.mltc@ontario.ca

[722374]

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #02 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 74 (2) (c)

The licensee has failed to comply with the process to monitor and document temperatures of foods served to residents in the home's dining rooms.

In accordance with O. Reg 246/22 s. 11(1)(b) the licensee is required to ensure the nutrition care and hydration program includes the implementation of interventions to mitigate and manage identified risks and is complied with.

Rationale and Summary
Specifically, staff did not comply with the home's food temperature control policy and procedure and the food temperature control – resident consumption policy and procedure.

The policies documented temperatures of all food were to be monitored to ensure foods were safe for consumption and to prevent the growth of and/or toxin production by pathogens in potentially hazardous foods. Hot food was to be held at 60 degrees Celsius (140 degrees Fahrenheit) or hotter and food items that held heat longer and had a risk of scalding or burning were to be served between 60 degrees Celsius to 70 degrees Celsius (140-160 Fahrenheit). Temperatures were to be recorded on the daily food temperature form immediately before service with corrective action taken if food was not at the correct temperature.

Food temperature logs gathered during the inspection from the small dining room did not have temperatures recorded on 22 meal periods over a three-week period. In the large dining room, temperatures were not recorded on 13 meal periods over a three-week period. A staff member indicated the home's process was to document food temperatures once it was brought to the dining room from the kitchen and before serving to residents.

The Food Nutrition Manager (FNM) confirmed temperatures should have been taken in the large dining room each meal period and staff likely felt rushed or stressed due to staffing levels. They indicated the small dining room temperatures may not have been completed if food was served from the large dining room when the steam well was broken. The FNM indicated the large dining room steam table had also been leaking and two wells did not have heat that week.

As a result of failing to check and document temperatures of food prior to service, there was a risk of residents receiving food that could lead to food borne illness if not hot enough, and risk of burning or scalding if food was too hot.

Sources: interviews with a staff member and the FNM, small and large dining room food temperature logs food temperature control policy and procedure and food temperature control – resident consumption policy and procedure.

[722374]

WRITTEN NOTIFICATION: Dining and Snack Service

NC #03 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 79 (1) 1.

The licensee has failed to ensure dining service included communication of the daily menu to residents.

Rationale and Summary
A complaint was submitted to the Ministry of Long-Term Care (MLTC) that included concerns of food served, specifically not knowing what food was provided with tray service.

The home's tray service policy documented residents who received tray service must be offered a choice by staff or volunteers that monitored the resident. A nutrition referral form would also be completed, printed, and sent to the kitchen before meal service began for residents that were being considered for tray service at mealtimes.

At the time of inspection, a staff member was observed delivering meals to resident rooms on the second floor during a lunch service. Documentation indicated there were 19 residents that were permanently on tray service for meals.

When asked how they knew what each resident was to receive from the menu choices, the staff member indicated they did not ask residents what they wanted to eat for lunch and were unsure if they were supposed to ask.

The staff member who prepared the meal trays for lunch on the date of observation indicated they chose the entrée for each resident's lunch because they were not informed of residents' choices by

staff. They stated a form used to be provided with the resident's menu choice for tray service, but this no longer occurred.

The FNM clarified it was the responsibility of PSWs to ask each resident in their room what their meal choice was and would verbally provide the information to the dietary staff or write the choice on a napkin. They indicated meal tray referral forms were no longer being used in the home.

As a result of not communicating menu choices to residents who received tray service in their rooms, there was a risk that residents would not like or eat the meal they received.

Sources: observations during lunch and dinner service in the large dining room, large dining room etiquette signage, interviews with a resident, staff members, and the FNM, tray service policy and procedure.

[722374]

WRITTEN NOTIFICATION: Dining and Snack Service

NC #04 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 79 (1) 5.

The licensee has failed to ensure food and fluids were served at a temperature that were both safe and palatable to residents.

Rationale and Summary
A complaint was submitted to the MLTC that included concerns regarding temperatures of foods provided through tray service in the home.

The home's tray service policy indicated meals would be portioned in insulated plate covers for additional heat retention.

The food temperature control policy and procedure documented temperatures of all food were to be monitored to ensure foods were safe for consumption and to prevent the growth of and/or toxin production by pathogens in potentially hazardous foods. Hot food was to be held at 60 degrees Celsius (140 degrees Fahrenheit) or hotter.

At the time of inspection, a staff member was observed to portion foods into Styrofoam containers on carts in the large dining room during lunch service. Documentation indicated there were 19 residents

who permanently ate meals in their rooms with the possible addition of four other residents each meal period. The last cart of meal trays was observed to be moved out of the dining room 24 minutes later by a staff member who started delivering meals to residents in their rooms.

The same cart was observed unattended 39 minutes later outside a resident room with a container of food and soup that was not warm to the touch. A staff member was then observed to offer this food to a resident 40 minutes after it was portioned. A staff member indicated when they had multiple residents to assist with meals in their rooms, they had to leave food on the cart until they were ready.

A resident was observed eating in their room with assistance from a staff member at the time of observations; there was half a meal in the Styrofoam container observed on the table. When asked how they found the temperature of their meal, the resident indicated it could have been warmer.

The FNM acknowledged delivering a meal to a resident 40 minutes after it was portioned was concerning due to being in the temperature danger zone. They stated the food should have been reheated or replaced at that time. Styrofoam containers were being used because the home did not have enough insulated plate covers for all residents.

By failing to keep food at safe and palatable temperatures for residents who received a meal tray in their room, there was a risk that residents would not eat the meal they received, and the meals could lead to food borne illness.

Sources: observations of lunch service at the time of inspection interviews with a resident, staff members, and the FNM, tray room service documentation, tray service policy and procedure, food temperature control policy and procedure, food temperature control – resident consumption policy and procedure.

[722374]