

## 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

	Original Public Report
Report Issue Date: June 26, 2023	
Inspection Number: 2023-1114-0004	
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	Inspector Digital Signature
Nuzhat Uddin (532)	
Additional Inspector(s)	
,	

### **INSPECTION SUMMARY**

The inspection occurred onsite on the following date(s): June 13-16, 20, 2023

The following intake(s) were inspected:

• Intake: #00087319 - Complaint related to oral care, plan of care, weight loss, and allegation of staff to resident abuse.

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

Resident Care and Support Services Infection Prevention and Control Prevention of Abuse and Neglect

## **INSPECTION RESULTS**



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# WRITTEN NOTIFICATION: Bill of Rights- 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. i.

The licensee of a long-term care home has failed to ensure that the following rights of residents were fully respected and promoted. The licensee failed to ensure that residents participated fully in the development, implementation, review and revision of their plan of care.

An intervention was implemented for a resident for the purpose of deterring residents from entering their room.

The resident stated that they were not consulted about the implementation of the intervention.

Director of care (DOC) acknowledged that the resident should have been included in the decision before applying the intervention.

The resident's rights were not promoted or respected when the home failed to ensure they participated in the development and implementation of their plan of care.

Sources: Resident's record review, observations, interview with the resident, the DOC and other staff.

[532]