Ontario

**Ministry of Health and Long-Term Care**

**Inspection Report under the Long-Term Care Homes Act, 2007**

**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée***

**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de 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 |
|---|---|---|---|
| Nov 20, 2018 | 2018_508137_0026 | 007920-18, 007923-18, 007925-18, 007926-18, 008990-18, 009196-18 | Follow up |

**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**

MARIAN MACDONALD (137), VALERIE GOLDRUP (539)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Follow up inspection.**

**This inspection was conducted on the following date(s): September 25-28, October 1-5, 9-12, 15-19 and 22, 2018.**

**The Follow up Inspection was completed related to:**
**Log #007920-18, follow up to Compliance Order # 001 related to developing and implementing a process for all residents demonstrating responsive behaviours to ensure strategies have been developed and implemented to respond to the**

**residents' responsive behaviours, issued on March 1, 2018, during Resident Quality Inspection (RQI) #2018_448155_0001, with a compliance date of March 12, 2018 and extended to July 30, 2018.**
**Log #007923-18, follow up to Compliance Order #002 related to procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents, issued on March 1, 2018, during Resident Quality Inspection (RQI) #2018_448155_0001, with a compliance date of March 12, 2018 and extended to July 30, 2018.**
**Log #007925-18, follow up to Compliance Order #003 related to plan of care not giving clear direction, issued on March 1, 2018, during Resident Quality Inspection (RQI) #2018_448155_0001, with a compliance date of April 6, 2018 and extended to August 15, 2018.**
**Log #007926-18, follow up to Compliance Order #004 related to not investigating complaints, issued on March 1, 2018, during Resident Quality Inspection (RQI) #2018_448155_0001, with a compliance date of April 6, 2018 and extended to August 30, 2018.**
**Log #009196-18, related to not complying with the Director's Order #003 for completing audits and coaching/mentoring of the Executive Director and Director of Care, issued May 3, 2018, during an Other Inspection #2018_448155_0002, with a compliance date of May 11, 2018 and extended to August 30, 2018.**

**PLEASE NOTE: A Written Notification and Compliance Order related to LTCHA, 2007, S.O. 2007, c.8, s.131(3) identified in a concurrent inspection #2018_027376-18 and Log #027376-18 were issued in this report.**

**During the course of the inspection, the inspector(s) spoke with Executive Director, Nurse Consultant - Responsive Health Management (RHM), Director of Operations - RHM, Resident Assessment Instrument (RAI) Coordinator, Director of Operations - Caressant Care, Director of Care, Physician, Social Worker, Regional Director - Caressant Care, Director of Clinical Service and Education - Caressant Care, Chief Operating Officer - Caressant Care, Resident Care Coordinator (RCC), Administrative Assistant, Nurse Clerks, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Maintenance Worker, Family and residents.**

**The Inspectors also conducted a tour of the home, observed resident care**

**provision and staff/resident interactions, reviewed residents' clinical records, Risk Management Reports, Complaints Binder, audits, employee files, staff schedules and education/training records and relevant policies and procedures.**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Hospitalization and Change in Condition**
**Personal Support Services**
**Reporting and Complaints**
**Responsive Behaviours**

**During the course of this inspection, Non-Compliances were issued.**
- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

**The following previously issued Order(s) were found to be in compliance at the time of this inspection:**
**Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:**

| REQUIREMENT/ EXIGENCE | TYPE OF ACTION/ GENRE DE MESURE | INSPECTION # / NO DE L'INSPECTION | INSPECTOR ID #/ NO DE L'INSPECTEUR |
|---|---|---|---|
| O.Reg 79/10 s. 101. (1) | CO #004 | 2018_448155_0001 | 539 |
| O.Reg 79/10 s. 53. (4) | CO #001 | 2018_448155_0001 | 137 |
| O.Reg 79/10 s. 55. | CO #002 | 2018_448155_0001 | 137 |
| LTCHA, 2007 S.O. 2007, c.8 s. 6. (1) | CO #003 | 2018_448155_0001 | 539 |

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence**

**Specifically failed to comply with the following:**

**s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.**

**Findings/Faits saillants :**

1. The licensee has failed to comply with the following requirement of the LTCHA: it is a condition of every licence that the licensee shall comply with every order made under this Act.

(A) On October 4, 2017, a Director's Order (DO #003) was made under LTCHA, 2007 S.O. 2007, c.8, s. 101 (3) and s. 101(4), Inspection #2017_508137_0018 with a compliance due date of October 31, 2017.
An Other inspection, #2018_448155_0002 and Log #004504-18, was conducted, in conjunction with Complaints, Critical Incident System and Follow up (CCF) inspections, between March 7 and April 13, 2018. Compliance Order #001 was served with a compliance due date of May 11, 2018, as the licensee failed to ensure that they implemented and followed their Plan of Corrective Action regarding Director Order #003, as submitted to the Director on October 19, 2017.
The licensee must comply with the following parts of the Plan of Corrective Action submitted by the licensee on October 19, 2017:
-After November 15, 2017 the Regional Manager/Nursing Consultant will conduct weekly visits. A review of status of compliance to orders will be part of each visit and reinforcement of plan put in place by the external consultant.
-The Regional Manager/Nurse Consultant will be conducting audits of Critical Incident System reports, consistency of assessments, review of falls assessments and review of responsive behaviour programs.
Any concerns or deficiencies identified in the audits shall be monitored, analyzed, and evaluated to improve the quality of care and services provided to the residents of the long-term care home. The audits shall be documented and kept in the home.
The licensee will provide coaching and mentoring support to the new Administrator/Executive Director and the new Director of Care relating to their respective roles and responsibilities specifically with respect to ensuring and sustaining compliance with requirements under the LTCHA.

The compliance due date for DO #003 was December 31, 2017, served as CO #001 with a compliance due date of May 11, 2018 and then extended to August 30, 2018.

Due to management instability in the home, the Director issued a Mandatory Management Order (MMO) on March 19, 2018. Responsive Health Management (RHM) commenced managing in the home on May 4, 2018.

Director of Care (DOC) #135 commenced employment on an identified date. A review of their employee file showed DOC #135 was provided orientation during a specified time period by RHM Nurse Consultant #103 and RHM Director of Operations #117. DOC #135 was no longer an employee of the home.

Executive Director (ED) #102 commenced employment on an identified date. A review of their employee file showed ED #102 was provided orientation during a specified time period by RHM Nurse Consultant #103 and RHM Director of Operations #117. At the time of this inspection, there were a significant amount of incomplete areas on the orientation checklist, specific to Caressant Care. Regional Manager/Nurse Consultant (RM/NC) #136 was to provide guidance, leadership and orientation but RM/NC was no longer an employee of the corporation.

ED #102 said they had been unable to complete the orientation, as the home was without a Director of Care and a Resident Care Coordinator (RCC). ED #102 said it would be arranged when the new DOC and RCC started.

During an interview, Chief Operation Officer (COO) #130 said arrangements had been made for an ED, from another home, to "buddy" with ED #102 to assist with and provide Caressant Care Executive Director Orientation. COO #130 said there was no definite time line set for the ED orientation to be completed.

DOC #119 commenced employment on an identified date. A review of their employee file showed three orientation checklists (25 pages) had been signed off as completed by DOC #119 and the Director of Clinical Service and Education #118. There was a Caressant Care Director of Care checklist, a RHM specific Orientation for Director of Care checklist and a Caressant Care all employees checklist.

During an interview, Inspector #137 asked DOC #119 how they were able to get through that information in two days. DOC #119 said they did not get through the information and it was an overview.

RHM #117 submitted a detailed plan to the Ministry related to the orientation of DOC #119. The plan was a collaborative orientation to be completed by Responsive Health Management and Caressant Care, with an identified completion date.

During the course of this inspection, there was no documented evidence that previous Regional Manager/Nurse Consultant #136 reviewed the status of the compliance orders

at each visit or reinforced the plan put in place by the previous external consultant. There was no documented evidence that the Regional Manager/Nurse Consultant #136 conducted audits of Critical Incident System reports, consistency of assessments, reviewed falls assessments and reviewed responsive behaviour programs. There were no concerns or deficiencies that could be monitored, analyzed and evaluated to improve the quality of care and services provided to the residents of the long-term care home.

According to the previous External Consultant's action plan of January 5, 2018, managers were to complete audits and place them in an Audit Binder. Inspector #137 asked RHM Nurse Consultant #103 and Executive Director #102 where the audit binder was. Neither were aware of it. RHM Nurse Consultant #103 was later able to locate a binder containing audits and the most recent ones completed were dated June 4, 2018, except one Medication Audit that was dated August 13, 2018. The audits were completed by Registered Nurses and not the Regional Manager/Nurse Consultant or Managers. There was no documented evidence of any audits being completed in July 2018.
On an identified date, RHM Nurse Consultant #103 provided two Critical Incident System (CIS) audits that they completed in July and August 2018. No other audits were available. The CIS report tracking tool was implemented the week of June 4, 2018.
During an interview, Resident Assessment Instrument (RAI) Coordinator #108 said there was a nursing department audit schedule, with specific audits to be completed daily, by the Registered Nurse on duty. They provided a copy of the schedule, as well as the following completed audits:
• Two Resident Safety Plan Audits (Falls) – September 2018
• Two Responsive Behaviour Audits – September 2018
• Two Resident Safety Plan Audits (Falls) – October 2018

RAI Coordinator #108 shared that the previous Resident Care Coordinator was responsible for scheduling, distributing and overseeing the audits but was no longer an employee of the home. Since then, the RAI Coordinator had been overseeing the nursing department audits. Now that there was a new DOC and RCC hired, RAI Coordinator #108 would be meeting with them to determine which one would be responsible for overseeing the audits.

The licensee has failed to comply with Director Order #003 from inspection #2017_508137_0018.

(B) The licensee failed to comply with the following requirement of the LTCHA: it is a condition of every licence that the licensee shall comply with every order made under this

Act.
On October 4, 2017, the following Director Order (DO #002) was made under LTCHA, 2007 S.O. 2007, c.8, s. 19.
1) To bring in a consultant from an external company with extensive experience in managing or operating LTC homes to conduct a review of the following areas and make recommendations for improvement regarding the following:
a. The falls and responsive behavior programs;
b. The other required programs as set out in the Long-Term Care Homes Act, 2007 (LTCHA), s.8-16 and O.Reg 79/10 s. 48;
c. The equipment available within the home to support the assessed care and safety needs of residents including bed alarms, chair alarms, and posey alarms.
2) Upon completion of the review the findings and recommendations will be set out in a report which will be provided by the consultant to both the licensee and the Director under the Act. This review and findings must be finalized no later than November 30, 2017.
3) Within two weeks of receiving the report from the review, the licensee will submit a plan to the Director identifying the recommendations that will be implemented and the time lines for implementation. That plan will be reviewed by the Director and may require changes based on the Director's review of the report and the plan submitted by the licensee. Upon approval of the plan by the Director, the licensee will implement the actions identified.

The plan was to be submitted to the Director by fax or courier by December 15, 2017. The compliance due date was December 31, 2017, extended to April 30, 2018 with another extension to July 30, 2018.

The final plan was submitted to the Director by fax on January 5, 2018. The plan stated that education of staff related to all the programs would be completed by April 30, 2018.

During an interview with Responsive Health Management, Nurse Consultant #100 they shared that Responsive Health Management started in the home on May 4, 2018 and that the previous external consultant finished in the home in May 2018. Responsive Health Management, Nurse Consultant #103 shared that any records that they had found regarding education to the programs was placed in the Education Binder that was provided to Inspectors for review. They also shared that nothing had been done with the Pain Management program in the home.

Review of the home's education records for the falls prevention policy education showed

that identified PSWs (14.5 per cent of the staff) had not completed education regarding the new falls policy.

Review of the home's education records for the responsive behaviours policy education showed that identified RN, RPNs and PSWs (16 per cent of the staff) had not completed education regarding the new responsive behaviour policy.

Review of the home's education records for the skin and wound care program showed that identified PSWs (11 per cent of the staff) had not completed education regarding the skin and wound management program.

Review of the home's education records for the continence care and bowel management program showed that identified PSWs (11 per cent of the staff) had not completed education regarding the bladder and bowel management program.

Review of the home's education records for the pain management program showed that identified PSWs (11 per cent of the staff) had not completed education regarding the pain assessment/pain management program.

Review of the Director Order #002 plan, submitted by Caressant Care also stated that for the falls prevention and management program, responsive behaviours program, skin and wound care program, continence care and bowel management program and the pain management program, there would be creation of computer modules for those that could not attend the mandatory education days and quizzes and sign off would be completed. Caressant Care Chief Operating Officer (COO) #130 shared that Responsive Health Management had expressed that there was no tracking of ongoing education in the home. COO #130 shared that the tracking for education was the tracking tool and the sign in sheets in the home's education binder. COO #130 stated that Surge learning modules were just getting set up and that they will be rolled out in 2019 across the corporation. There was no education to the revised program policies and procedures in a computer module.

During an interview, Executive Director #102 said that they could not find any further education records related to the above employees receiving the mandatory education as outlined in the plan submitted to the Director.

Review of the Director Order #002 plan submitted by Caressant Care for the responsive behaviours program stated that there would be Gentle Persuasive Approaches (GPA)

training for front line staff and activation staff. During interviews with Behaviour Support RPN #113 they shared that GPA training had never been offered to the front line staff and activation staff during their employment of fifteen years. During an interview with COO #130 they shared that GPA training for front line staff and activation staff had not taken place. The plan also stated that there would be Code White training and Form 1 training. During an interview with Behaviour Support RPN #113 they shared that there had been no Form 1 training to any staff.

Review of the education record for Code White training showed that identified PSWs (11 per cent of the nursing staff) had not completed the education. Executive Director #102 shared that not all staff were educated to Code White.

Review of the Director Order #002 plan submitted by Caressant Care for the pain management program stated that there would be revision/rewrite and enhancements to the existing policy and procedure and that the procedure would include monitoring periods. . Review of the Caressant Care Fergus policy titled Pain Assessment/Management Program with effective and reviewed date of April 2018, it was identified that monitoring periods were included.

A hard copy policy manual was kept at the Central Nursing Station.

During interview with RN #104 they shared that the policy did not give them clear direction on what was to be done in regards to pain assessment/management. During interview with RAI Coordinator #108 they shared that they noted that this policy seemed to still be in draft form and that they had brought that to the attention of Responsive Health Management, Nurse Consultant #103.

During interview with Executive Director #102 and Responsive Health Management, Director of Operations #117 a review of the Pain Assessment/Management Program Policy was done. They both stated that the policy did not seem to be complete and that it seemed it was the draft policy. They agreed that the policy did not provide clear direction on what pain assessments were to be done when and for what period of time.

Review of the Director Order #002 plan submitted by Caressant Care for the falls prevention and management program stated that there would be development of new audit tools for falls.The review of the Quality Program and additional audits and/or revisions to existing audits would be completed for the program. Review of the Nursing Department Daily Audits schedule done on October 18, 2018 did not include the

Resident Safety Plan audit. Review of audit binder for 2018 revealed that from July 31, 2018 to October 18, 2018 there had been four Resident Safety Plan Audits completed.

Review of the Director Order #002 plan dated submitted by Caressant Care for the responsive behaviour program stated that there would be review of the quality program and additional audits and or revisions to current audits would be completed for this program. This included tracking and sustainability audits and a schedule, walk about audits for management team, and reporting structure for CQI plans and correction. During interview with COO #130 they shared that the audit binder was kept in the RAI Coordinator's office.

Review of the Nursing Department Daily Audits schedule showed that Responsive Behaviour Audits were to be done on Wednesdays by the RN Supervisor. The Annual Calendar of Activities Nursing for 2018 indicated audits were to be done monthly but was scheduled in March, June, September and December. Review of the audit binder for 2018 revealed that from July 31, 2018 to October 18, 2018 there had been two Responsive Behaviour audits completed and one audit done of the Responsive Behaviour meetings. Executive Director #102 shared that there were no other audits completed that they were aware of.

Review of the Director Order #002 plan submitted by Caressant Care for the skin and wound care program stated that there would be creation of new audits that allowed for review of the program. Review of the Nursing Department Daily Audits schedule done showed that Skin and Wound Care audits were to be done on Mondays by the RN Supervisor. Review of the audit binder for 2018 showed that from July 31, 2018 to October 18, 2018 there had been three Skin and Wound Care audits completed by registered staff. There was one audit completed on July 31, 2018 by Responsive Health Management Nurse Consultant #103 of the skin and wound program that identified that not all staff were proficient in the use of the Point Click Care skin and wound application. During interview with RN #104 they shared that as of August 2018 they were the wound care champion in the home. RN #104 also shared that they had not received training on the use of the camera and the Point Click Care skin and wound assessment application.

Review of the Director Order #002 plan submitted by Caressant Care for the continence care and bowel management program stated that there would be sustainability through auditing on schedule and reporting and creation of action plans. Review of the Nursing Department Daily Audits schedule showed that Continence Care Audits were to be done on Saturdays by the RN Supervisor. The Annual Calendar of Activities Nursing for 2018

indicated an audit was to be done quarterly in March, June, September, and December. Review of the audit binder for 2018 showed that from July 31, 2018 to October 18, 2018 there were two Continence Care audits competed.

Review of the Director Order #002 plan submitted by Caressant Care for the pain management program stated that there would be ongoing audits to ensure that pain was controlled and adjusted as needed. Review of the Nursing Department Daily Audits schedule showed that Pain Management Audits were to be completed on Tuesday by the RN Supervisor. The Annual Calendar of Activities-Nursing for 2018 indicated audits were to be done quarterly in March, June, September and December by registered staff. Review of the audit binder for 2018 showed that from July 31, 2018 to October 18, 2018 there had been two Pain Management audits completed by registered staff.

Executive Director #102 was asked if there were any other audits that had been completed regarding the programs being reviewed in DO #002. Executive Director #102 shared that they had no knowledge of any other audits.

The licensee has failed to comply with Director Order #002 from inspection #2017_508137_0018. [S. 101. (3)]

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**Issued on this 23rd day of November, 2018**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

**Order(s) of the Inspector**

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

**Ministère de la Santé et des Soins de longue durée**

**Ordre(s) de l'inspecteur**

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

**Long-Term Care Homes Division**
**Long-Term Care Inspections Branch**

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | MARIAN MACDONALD (137), VALERIE GOLDRUP (539) |
| **Inspection No. / No de l'inspection :** | 2018_508137_0026 |
| **Log No. / No de registre :** | 007920-18, 007923-18, 007925-18, 007926-18, 008990-18, 009196-18 |
| **Type of Inspection / Genre d'inspection:** | Follow up |
| **Report Date(s) / Date(s) du Rapport :** | Nov 20, 2018 |
| **Licensee / Titulaire de permis :** | Caressant-Care Nursing and Retirement Homes Limited<br>264 Norwich Avenue, WOODSTOCK, ON, N4S-3V9 |
| **LTC Home / Foyer de SLD :** | Caressant Care Fergus Nursing Home<br>450 Queen Street East, FERGUS, ON, N1M-2Y7 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Penny Silva |

Ontario

**Ministry of Health and Long-Term Care**

**Ministère de la Santé et des Soins de longue durée**

## Order(s) of the Inspector

## Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

To Caressant-Care Nursing and Retirement Homes Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

**Ministry of Health and Long-Term Care**

**Order(s) of the Inspector**

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

**Ministère de la Santé et des Soins de longue durée**

**Ordre(s) de l'inspecteur**

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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**Order # /**
**Ordre no :** 001

**Order Type /**
**Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

**Linked to Existing Order /**
**Lien vers ordre existant:** 2018_448155_0002, CO #001;

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

**Order / Ordre :**

The licensee must be compliant with s.101 (3) of the LTCHA.

• The licensee shall provide coaching and mentoring support to the new Executive Director and the new Director of Care relating to their respective roles and responsibilities, specifically with respect to ensuring and sustaining compliance with requirements under the LTCHA, as well as ensuring orientation, to their respective roles, is fully completed.
• The licensee shall ensure the following:
Identified PSWs, RPN and all newly hired staff complete education related to the new falls policy.
Identified PSWs, RN, RPNs, and all newly hired staff complete education related to the new responsive behaviours policy. In addition, identified PSWs and all newly hired staff complete education related to Code White training. All responsive behaviour training, including the homes gentle persuasion approach for front line staff and activation staff, are provided.
Identified PSWs and all newly hired direct care staff complete education related to the skin and wound management program.
Identified PSWs and all newly hired direct care staff complete education related to the continence care and bowel management program.
• The licensee shall complete the review and revisions of the Pain Management Program policy and implement it in the home.
• The licensee shall educate the staff on the Pain Management Program policy and keep record of this education in the home.
• All education records shall be documented and kept in the home.
• Audits shall be completed related to the required programs and the licensee will designate a responsible person to monitor, analyze and evaluate any concerns or deficiencies identified to improve the quality of care and services provided to the residents of the long-term care home. The audits shall be documented and kept in the home.

**Grounds / Motifs :**

1. The licensee has failed to comply with Director Orders #002 and #003 from inspection #2017_508137_0018.
(A) On October 4, 2017, a Director's Order (DO #003) was made under LTCHA, 2007 S.O. 2007, c.8, s. 101 (3) and s. 101(4), Inspection #2017_508137_0018 with a compliance due date of October 31, 2017.
An Other inspection, #2018_448155_0002 and Log #004504-18, was

conducted, in conjunction with Complaints, Critical Incident System and Follow up (CCF) inspections, between March 7 and April 13, 2018. Compliance Order #001 was served with a compliance due date of May 11, 2018, as the licensee failed to ensure that they implemented and followed their Plan of Corrective Action regarding Director Order #003, as submitted to the Director on October 19, 2017.
The licensee must comply with the following parts of the Plan of Corrective Action submitted by the licensee on October 19, 2017:
-After November 15, 2017 the Regional Manager/Nursing Consultant will conduct weekly visits. A review of status of compliance to orders will be part of each visit and reinforcement of plan put in place by the external consultant.
-The Regional Manager/Nurse Consultant will be conducting audits of Critical Incident
System reports, consistency of assessments, review of falls assessments and review of responsive behaviour programs.
Any concerns or deficiencies identified in the audits shall be monitored, analyzed, and evaluated to improve the quality of care and services provided to the residents of the long-term care home. The audits shall be documented and kept in the home.
The licensee will provide coaching and mentoring support to the new Administrator/Executive Director and the new Director of Care relating to their respective roles and responsibilities specifically with respect to ensuring and sustaining compliance with requirements under the LTCHA.

The compliance due date for DO #003 was December 31, 2017, served as CO #001 with a compliance due date of May 11, 2018 and then extended to August 30, 2018.

Due to management instability in the home, the Director issued a Mandatory Management Order (MMO) on March 19, 2018. Responsive Health Management (RHM) commenced managing in the home on May 4, 2018.

Director of Care (DOC) #135 commenced employment on an identified date. A review of their employee file showed DOC #135 was provided orientation during a specified time period by RHM Nurse Consultant #103 and RHM Director of Operations #117. DOC #135 was no longer an employee of the home.

Executive Director (ED) #102 commenced employment on an identified date. A review of their employee file showed ED #102 was provided orientation during a specified time period by RHM Nurse Consultant #103 and RHM Director of Operations #117. At the time of this inspection, there were a significant amount of incomplete areas on the orientation checklist, specific to Caressant Care. Regional Manager/Nurse Consultant (RM/NC) #136 was to provide guidance, leadership and orientation but RM/NC was no longer an employee of the corporation.

ED #102 said they had been unable to complete the orientation, as the home was without a Director of Care and a Resident Care Coordinator (RCC). ED #102 said it would be arranged when the new DOC and RCC started.

During an interview, Chief Operation Officer (COO) #130 said arrangements had been made for an ED, from another home, to "buddy" with ED #102 to assist with and provide Caressant Care Executive Director Orientation. COO #130 said there was no definite time line set for the ED orientation to be completed.

DOC #119 commenced employment on an identified date. A review of their employee file showed three orientation checklists (25 pages) had been signed off as completed by DOC #119 and the Director of Clinical Service and Education #118. There was a Caressant Care Director of Care checklist, a RHM specific Orientation for Director of Care checklist and a Caressant Care all employees checklist.

During an interview, Inspector #137 asked DOC #119 how they were able to get through that information in two days. DOC #119 said they did not get through the information and it was an overview.

RHM #117 submitted a detailed plan to the Ministry related to the orientation of DOC #119. The plan was a collaborative orientation to be completed by Responsive Health Management and Caressant Care, with an identified completion date.

During the course of this inspection, there was no documented evidence that previous Regional Manager/Nurse Consultant #136 reviewed the status of the compliance orders at each visit or reinforced the plan put in place by the

previous external consultant. There was no documented evidence that the Regional Manager/Nurse Consultant #136 conducted audits of Critical Incident System reports, consistency of assessments, reviewed falls assessments and reviewed responsive behaviour programs. There were no concerns or deficiencies that could be monitored, analyzed and evaluated to improve the quality of care and services provided to the residents of the long-term care home.

According to the previous External Consultant's action plan of January 5, 2018, managers were to complete audits and place them in an Audit Binder. Inspector #137 asked RHM Nurse Consultant #103 and Executive Director #102 where the audit binder was. Neither were aware of it. RHM Nurse Consultant #103 was later able to locate a binder containing audits and the most recent ones completed were dated June 4, 2018, except one Medication Audit that was dated August 13, 2018. The audits were completed by Registered Nurses and not the Regional Manager/Nurse Consultant or Managers. There was no documented evidence of any audits being completed in July 2018.
RHM Nurse Consultant #103 provided two Critical Incident System (CIS) audits that they completed in July and August 2018. No other audits were available. The CIS report tracking tool was implemented the week of June 4, 2018.
During an interview, Resident Assessment Instrument (RAI) Coordinator #108 said there was a nursing department audit schedule, with specific audits to be completed daily, by the Registered Nurse on duty. They provided a copy of the schedule, as well as the following completed audits:
• Two Resident Safety Plan Audits (Falls) – September 2018
• Two Responsive Behaviour Audits – September 2018
• Two Resident Safety Plan Audits (Falls) – October 2018

RAI Coordinator #108 shared that the previous Resident Care Coordinator was responsible for scheduling, distributing and overseeing the audits but was no longer an employee of the home. Since then, the RAI Coordinator had been overseeing the nursing department audits. Now that there was a new DOC and RCC hired, RAI Coordinator #108 would be meeting with them to determine which one would be responsible for overseeing the audits.

The licensee has failed to comply with Director Order #003 from inspection #2017_508137_0018.

(B) The licensee failed to comply with the following requirement of the LTCHA: it is a condition of every licence that the licensee shall comply with every order made under this Act.
On October 4, 2017, the following Director's order (DO #002) was made under LTCHA, 2007 S.O. 2007, c.8, s. 19.
1) To bring in a consultant from an external company with extensive experience in managing or operating LTC homes to conduct a review of the following areas and make recommendations for improvement regarding the following:
a. The falls and responsive behavior programs;
b. The other required programs as set out in the Long-Term Care Homes Act, 2007 (LTCHA), s.8-16 and O.Reg 79/10 s. 48;
c. The equipment available within the home to support the assessed care and safety needs of residents including bed alarms, chair alarms, and posey alarms.
2) Upon completion of the review the findings and recommendations will be set out in a report which will be provided by the consultant to both the licensee and the Director under the Act. This review and findings must be finalized no later than November 30, 2017.
3) Within two weeks of receiving the report from the review, the licensee will submit a plan to the Director identifying the recommendations that will be implemented and the time lines for implementation. That plan will be reviewed by the Director and may require changes based on the Director's review of the report and the plan submitted by the licensee. Upon approval of the plan by the Director, the licensee will implement the actions identified.

The plan was to be submitted to the Director by fax or courier by December 15, 2017.
The compliance due date was December 31, 2017, extended to April 30, 2018 with another extension to July 30, 2018.

The final plan was submitted to the Director by fax on January 5, 2018. The plan stated that education of staff related to all the programs would be completed by April 30, 2018.

During an interview with Responsive Health Management, Nurse Consultant #100 they shared that Responsive Health Management started in the home on May 4, 2018 and that the previous external consultant finished in the home in

May 2018. Responsive Health Management, Nurse Consultant #103 shared that any records that they had found regarding education to the programs was placed in the Education Binder that was provided to Inspectors for review. They also shared that nothing had been done with the Pain Management program in the home.

Review of the home's education records for the falls prevention policy education showed that identified PSWs and RPN (14.5 per cent of the staff) had not completed education regarding the new falls policy.

Review of the home's education records for the responsive behaviours policy education showed that identified RN, RPNs and PSWs (16 per cent of the staff) had not completed education regarding the new responsive behaviour policy.

Review of the home's education records for the skin and wound care program showed that identified PSWs (11 per cent of the staff) had not completed education regarding the skin and wound management program.

Review of the home's education records for the continence care and bowel management program showed that identified PSWs (11 per cent of the staff) had not completed education regarding the bladder and bowel management program.

Review of the home's education records for the pain management program showed that identified PSWs (11 per cent of the staff) had not completed education regarding the pain assessment/pain management program.

Review of the Director Order #002 plan submitted by Caressant Care also stated that for the falls prevention and management program, responsive behaviours program, skin and wound care program, continence care and bowel management program and the pain management program, there would be creation of computer modules for those that could not attend the mandatory education days and quizzes and sign off would be completed. Caressant Care Chief Operating Officer (COO) #130 shared that Responsive Health Management had expressed that there was no tracking of ongoing education in the home. COO #130 shared that the tracking for education was the tracking tool and the sign in sheets in the home's education binder. COO #130 stated that

Surge learning modules were just getting set up and that they would be rolled out in 2019 across the corporation. There was no education to the revised program policies and procedures in a computer module.

Executive Director #102 said that they could not find any further education records related to the above employees receiving the mandatory education as outlined in the plan submitted to the Director.

Review of the Director Order #002 plan submitted by Caressant Care for the responsive behaviours program stated that there would be Gentle Persuasive Approaches (GPA) training for front line staff and activation staff. During interviews with Behaviour Support RPN #113 they shared that GPA training had never been offered to the front line staff and activation staff during their employment of fifteen years. During an interview with COO #130 they shared that GPA training for front line staff and activation staff had not taken place. The plan also stated that there would be Code White training and Form 1 training. During an interview with Behaviour Support RPN #113 they shared that there had been no Form 1 training to any staff.

Review of the education record for Code White training showed that identified PSWs (11 per cent of the nursing staff) had not completed the education. Executive Director #102 shared that not all staff were educated to Code White.

Review of the Director Order #002 plan submitted by Caressant Care for the pain management program stated that there would be revision/rewrite and enhancements to the existing policy and procedure and that the procedure would include monitoring periods. Review of the Caressant Care Fergus policy titled Pain Assessment/Management Program with effective and reviewed date of April 2018, it was identified that monitoring periods were included.

A hard copy policy manual was kept at the Central Nursing Station.
During an interview with RN #104, they shared that the policy did not give them clear direction on what was to be done in regards to pain assessment/management. During interview with RAI Coordinator #108 they shared that they noted that this policy seemed to still be in draft form and that they had brought that to the attention of Responsive Health Management, Nurse Consultant #103.

During an interview with Executive Director #102 and Responsive Health Management, Director of Operations #117 a review of the Pain Assessment/Management Program Policy was done. They both stated that the policy did not seem to be complete and that it seemed it was the draft policy. They agreed that the policy did not provide clear direction on what pain assessments were to be done when and for what period of time.

Review of the Director Order #002 plan submitted by Caressant Care for the falls prevention and management program stated that there would be development of new audit tools for falls. The review of the Quality Program and additional audits and/or revisions to existing audits would be completed for the program. Review of the Nursing Department Daily Audits schedule done on October 18, 2018 did not include the Resident Safety Plan audit. Review of audit binder for 2018 revealed that from July 31, 2018 to October 18, 2018 there had been four Resident Safety Plan Audits completed.

Review of the Director Order #002 plan submitted by Caressant Care for the responsive behaviour program stated that there would be review of the quality program and additional audits and or revisions to current audits would be completed for this program. This included tracking and sustainability audits and a schedule, walk about audits for management team, and reporting structure for CQI plans and correction. On October 16, 2018 during interview with COO #130 they shared that the audit binder was kept in the RAI Coordinator's office.

Review of the Nursing Department Daily Audits schedule showed that Responsive Behaviour Audits were to be done on Wednesdays by the RN Supervisor. The Annual Calendar of Activities Nursing for 2018 indicated audits were to be done monthly but was scheduled in March, June, September and December. Review of audit binder for 2018 revealed that from July 31, 2018 to October 18, 2018 there had been two Responsive Behaviour audits completed and one audit done of the Responsive Behaviour meetings. Executive Director #102 shared that there were no other audits completed that they were aware of.

Review of the Director Order #002 plan submitted by Caressant Care for the skin and wound care program stated that there would be creation of new audits that allowed for review of the program. Review of the Nursing Department Daily

Audits schedule done showed that Skin and Wound Care audits were to be done on Mondays by the RN Supervisor. Review of the audit binder for 2018 showed that from July 31, 2018 to October 18, 2018 there had been three Skin and Wound Care audits completed by registered staff. There was one audit completed on July 31, 2018 by Responsive Health Management Nurse Consultant #103 of the skin and wound program that identified that not all staff were proficient in the use of the Point Click Care skin and wound application. On October 19, 2018, during interview with RN #104 they shared that as of August 2018 they were the wound care champion in the home. RN #104 also shared that they had not received training on the use of the camera and the Point Click Care skin and wound assessment application.

Review of the Director Order #002 plan submitted by Caressant Care for the continence care and bowel management program stated that there would be sustainability through auditing on schedule and reporting and creation of action plans. Review of the Nursing Department Daily Audits schedule showed that Continence Care Audits were to be done on Saturdays by the RN Supervisor. The Annual Calendar of Activities Nursing for 2018 indicated an audit was to be done quarterly in March, June, September, and December. Review of the audit binder for 2018 showed that from July 31, 2018 to October 18, 2018 there were two Continence Care audits competed.

Review of the Director Order #002 plan submitted by Caressant Care for the pain management program stated that there would be ongoing audits to ensure that pain iwas controlled and adjusted as needed. Review of the Nursing Department Daily Audits schedule showed that Pain Management Audits were to be completed on Tuesday by the RN Supervisor. The Annual Calendar of Activities-Nursing for 2018 indicated audits were to be done quarterly in March, June, September and December by registered staff. Review of the audit binder for 2018 showed that from July 31, 2018 to October 18, 2018 there had been two Pain Management audits completed by registered staff.

Executive Director #102 was asked if there were any other audits that had been completed regarding the programs being reviewed in DO #002. Executive Director #102 shared that they had no knowledge of any other audits.

The licensee has failed to comply with Director Order #003 from inspection

#2017_508137_0018.

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm to the residents. The scope of the issue was a level 3 as it had the potential to affect all residents in the home. Compliance history was a level 4 as there was ongoing related non compliance in the last 36 months.

(137)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Dec 31, 2018

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

## RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

**Issued on this 20th day of November, 2018**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** MARIAN MACDONALD

**Service Area Office /**
**Bureau régional de services :** Central West Service Area Office