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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
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Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Dec 19, 2019	2019_793743_0020	021285-19	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

KIYOMI KORNETSKY (743)

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): November 27-29, and December 2, 2019.

The following intake was completed in this Critical Incident inspection, which was completed in conjunction with Complaint inspection #2019_793743_0021.
Log #021285-19 / CI 2603-000066-19 related to the unexpected death of a resident.

During the course of the inspection, the inspector(s) spoke with the Acting Director of Care, Resident Care Coordinator (RCC), Registered Nurses (RN) and Personal Support Workers (PSW).

The inspector reviewed clinical records and plans of care for relevant residents; and observations were made of residents and resident care provisions.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **1 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. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 49 (1).

Findings/Faits saillants :

1. The home failed to ensure the falls prevention program provided for strategies to reduce or mitigate falls, including the use of equipment.

Critical Incident (CI) #2603-000066-19 was submitted to the Ministry of Long-Term Care (MLTC) related to the unexpected death of resident #001. The coroner noted that the immediate cause of death resulted from an injury sustained at the home.

Documentation in Point Click Care (PCC) indicated that nine days prior to resident #001's death, they sustained an injury at the home.

Personal Support Worker (PSW) #100 said resident #001 did not have an appropriate mobility device, which placed the resident at risk.

Five months prior to resident #001's death, Occupational Therapist (OT) #102 documented that resident #001's current mobility device was not appropriate for the resident.

One month later, OT #102 documented that that they had obtained consent from resident #001's substitute decision maker (SDM) to proceed with assessments for a new mobility device.

There was no further documentation about resident #001's new mobility device until four months later, when the home's newly hired OT #103 documented that resident #001 required a new mobility device; as their current mobility device placed them at risk for injury.

OT #103 reported that it was their observation of resident #001 in their current mobility device that prompted their assessment. Prior to their assessment, they had not been informed that the resident was using an inappropriate mobility device, nor that the previous OT #102 had obtained consent from the resident's SDM to obtain a new device.

Between the period of OT #102's initial assessment of resident #001's mobility device and OT #103's assessment, resident #001 had three separate incidents that resulted in injuries.

The resident's final incident involving their mobility device occurred nine days prior to the resident's death. RN #101 said they were walking to a specific area in the home, when they observed resident #001 in their mobility device. As they entered another area of the home, they heard a loud bang and the resident was noted to have sustained an injury.

OT #103 contacted the family of resident #001 three days later, to discuss obtaining the resident a new mobility device, and was informed by the family that they had been unclear as to why the resident had yet to receive their new mobility device.

Resident Care Coordinator (RCC) #104 said resident #001 never received their new mobility device due to a gap in the process. They said that although OT #102 initiated the process of obtaining a new mobility device for resident #001, there was no follow up until the month the resident passed away.

Resident #001 passed nine days after an incident involving their mobility device; and the coroner noted that the immediate cause of death was complications from an injury that resulted from an incident at the home.

The licensee failed to ensure that the falls prevention and management program provided, at a minimum, strategies to reduce or mitigate falls, including the use of equipment; when they failed to provide resident #001 with an appropriate mobility device, after their current mobility device was identified as a safety risk. [s. 49. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

The following is further evidence to support Compliance Order (CO) #004, issued on Nov 19, 2019, during Follow Up inspection 2019_727695_0025 (A1); to be complied February 25, 2020.

Critical Incident (CI) #2603-000066-19 was submitted to the Ministry of Long-Term Care (MLTC) related to the unexpected death of resident #001. The coroner noted that the immediate cause of death resulted from an injury sustained at the home.

Documentation in PCC indicated that nine days prior to resident #001's death, the resident had an unwitnessed incident while using their mobility device in a specific area of the home.

Records indicated that resident #001 had a history of incidents; including three previous incidents that involved their mobility device. The resident was documented as sustaining injuries after each incident; and a specific intervention was put in place to help mitigate the resident's risk of injury related to their mobility device.

PSW #100 said resident #001 was at risk of injury while using their mobility device; and as a safety precaution, the plan of care instructed staff to follow a specific intervention.

According to RN #010, on the day of resident #001's final incident, they were walking to a specific area of the home when they observed the resident using their mobility device. RN #010 said they heard a loud bang and the resident was noted to have sustained an injury. According to resident #001's plan of care, the resident should not have been using their mobility device at that time, and in that particular area of the home.

The licensee failed to ensure that the care set out in the plan of care for resident #001,was provided to the resident as specified in the plan; when staff failed to follow the resident's specific intervention related the resident's mobility device, which resulted in the resident's injury and subsequent death. [s. 6. (7)]

Issued on this 23rd day of December, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	KIYOMI KORNETSKY (743)
Inspection No. / No de l'inspection :	2019_793743_0020
Log No. / No de registre :	021285-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 19, 2019
Licensee / Titulaire de permis :	Caressant-Care Nursing and Retirement Homes Limited 264 Norwich Avenue, WOODSTOCK, ON, N4S-3V9
LTC Home / Foyer de SLD :	Caressant Care Fergus Nursing Home 450 Queen Street East, FERGUS, ON, N1M-2Y7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Debbie Boakes

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:

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

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 49. (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 49 (1).

Order / Ordre :

The licensee must be compliant with s. 49(1) of the O.Reg. 79/10.

Specifically, the licensee must:

a) ensure that the falls prevention and management program provides residents with equipment that meets their individual needs.

b) ensure that there is a designated person employed by the home, who works with the Occupational Therapist to oversea the equipment needs for all residents.

c) ensure that the Occupational Therapist or designate, communicates with the substitute decision maker(s) and members of the health care team regarding the status of the equipment and interim safety measures.

d) ensure that an audit tool is developed and implemented in relation to falls prevention equipment for residents. The audit should be documented and include who is responsible, the results and the actions taken in relation to the results.

Grounds / Motifs :

1. The home failed to ensure the falls prevention program provided for strategies to reduce or mitigate falls, including the use of equipment.

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Term Care (MLTC) related to the unexpected death of resident#001. The coroner noted that the immediate cause of death resulted from an injury sustained at the home.

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OT #103 reported that it was their observation of resident #001 in their current mobility device that prompted their assessment. Prior to their assessment, they had not been informed that the resident was using an inappropriate mobility device, nor that the previous OT #102 had obtained consent from the resident's SDM to obtain a new device.

Between the period of OT #102's initial assessment of resident #001's mobility device and OT #103's assessment, resident #001 had three separate incidents that resulted in injuries.

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Resident #001 passed nine days after an incident involving their mobility device; and the coroner noted that the immediate cause of death was complications from an injury that resulted from an incident at the home.

The licensee failed to ensure that the falls prevention and management program provided, at a minimum, strategies to reduce or mitigate falls, including the use of equipment; when they failed to provide resident #001 with an appropriate mobility device, after their current mobility device was identified as a safety risk. [s. 49. (1)]

The severity of this issue was determined to be a level 4 as there was serious harm to the resident. The scope of the issue was a level 1 as it related one out of three residents reviewed. The home had a level 2 compliance history as there was previous non-compliance to a different subsection. (743)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 15, 2020

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 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 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 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 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 19th day of December, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Kiyomi Kornetsky

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