

**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  
Facsimile: (519) 885-2015

Bureau régional de services de Centre  
Ouest  
1e étage, 609 rue Kumpf  
WATERLOO ON N2V 1K8  
Téléphone: (888) 432-7901  
Télécopieur: (519) 885-2015

**Public Copy/Copie du rapport public**

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| <b>Report Date(s) /<br/>Date(s) du Rapport</b> | <b>Inspection No /<br/>No de l'inspection</b> | <b>Log # /<br/>No de registre</b> | <b>Type of Inspection /<br/>Genre d'inspection</b> |
|--|---|-----------------------------------|--|
| Nov 4, 2020                                    | 2020_800532_0021                              | 015521-20                         | Follow up  |

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**Licensee/Titulaire de permis**

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

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

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

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

NUZHAT UDDIN (532)

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**Inspection Summary/Résumé de l'inspection**

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

**This inspection was conducted on the following date(s): October 1-8, 2020.**

**The following intake was completed during this inspection: Log #015521-20 follow-up related to pain assessment.**

**Please note: This Follow-up inspection was completed concurrently with a Critical Incident inspection #2020\_800532\_0022.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Care (ADOC), Environmental Manager, Registered Nurses, (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), family member and residents.**

**The inspector also toured resident home areas, observed resident care provision, administration of medications, resident staff interaction, and reviewed relevant residents' clinical records, policies and procedures and training records pertaining to the inspection.**

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

**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)**

**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:**

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| REQUIREMENT/<br>EXIGENCE  | TYPE OF ACTION/<br>GENRE DE MESURE | INSPECTION # /<br>DE L'INSPECTION | NO | INSPECTOR ID #/<br>NO DE L'INSPECTEUR |
|---------------------------|------------------------------------|-----------------------------------|----|---------------------------------------|
| O.Reg 79/10 s. 52.<br>(2) | CO #001                            | 2020_800532_0009                  |    | 532                                   |

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

| Legend  | Légende  |
|---|--|
| <p>WN – Written Notification<br/>VPC – Voluntary Plan of Correction<br/>DR – Director Referral<br/>CO – Compliance Order<br/>WAO – Work and Activity Order</p>  | <p>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</p>   |
| <p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p> | <p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p> |

**WN #1: 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,**

**(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).**

**(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).**

**(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

**s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised, (a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).**

**(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a resident was reassessed, and the plan of care reviewed and revised when the resident's care needs changed.

Directions related to activities of daily living (ADL) were provided to staff in a resident's plan of care.

Observations of the resident showed they had a decline in health status and directions for the activities of daily living had not been revised to reflect their current needs.

The resident's plan of care was not revised when their care needs changed which posed a risk to the resident should the appropriate level of care not be provided.

Sources: plan of care, observations, PSWs, RPNs, RN and other staff members. [s. 6. (10) (b)]

2. The licensee has failed to ensure that when a resident was reassessed related to pain management and the plan of care was revised because care set out in the plan had not been effective, different approaches were considered in the revision of the plan of care.

A resident had a decline in health status and demonstrated signs and symptoms of unrelenting pain and disability. During the revision of the resident's plan of care, new approaches to care were not considered.

Sources : Electronic medication administration record, plan of care, pain policy, weights and vitals summary, PSWs , RN, Physiotherapist and other staff. [s. 6. (11) (b)]

***Additional Required Actions:***

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

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care**

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

**s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that resident #001 received preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

A resident was to have their nails manicured when they were bathed but this had not been done causing potential for skin breakdown.

Sources: plan of care, observations, PSWs, RPN, RN and the Administrator. [s. 35. (1)]

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**Issued on this 5th day of November, 2020**

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

**Original report signed by the inspector.**

**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

Long-Term Care Operations Division  
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Division des opérations relatives aux soins de longue durée  
Inspection de soins de longue durée

**Public Copy/Copie du rapport public**

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**Name of Inspector (ID #) /**

**Nom de l'inspecteur (No) :** NUZHAT UDDIN (532)

**Inspection No. /**

**No de l'inspection :** 2020\_800532\_0021

**Log No. /**

**No de registre :** 015521-20

**Type of Inspection /**

**Genre d'inspection:** Follow up

**Report Date(s) /**

**Date(s) du Rapport :** Nov 4, 2020

**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 :** Angel Roth

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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****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

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l'article 154 de la *Loi de 2007 sur les  
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2007, chap. 8

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**Order # /****No d'ordre :** 001**Order Type /****Genre d'ordre :** Compliance Orders, s. 153. (1) (a)**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,

(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and

(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

**Order / Ordre :**

The licensee must be compliant with s. 6. (11) (b) of the LTCHA.

Specifically, the licensee must:

- 1) Refer an identified resident to a pain consultant and/or Pharmacist to conduct a medication review.
- 2) Ensure the home monitors the resident responses to and effectiveness of the pain management strategies with a goal of managing the resident's pain.
- 3) Establish a pain and palliative committee, as part of the pain management program, consisting of representatives from different disciplines. The committee will collaborate to review complex cases, identify goals, make suggestions for next steps and evaluate pain management for those cases. Minutes of the meetings must be documented and include the date, staff in attendance and outcome of the meeting.

**Grounds / Motifs :**



**Order(s) of the Inspector**

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

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
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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

1. The licensee has failed to ensure that when a resident was reassessed related to pain management and the plan of care was revised because care set out in the plan had not been effective, different approaches were considered in the revision of the plan of care.

A resident had a decline in health status and demonstrated signs and symptoms of unrelenting pain and disability. During the revision of the resident's plan of care, new approaches to care were not considered.

Sources : Electronic medication administration record, plan of care, pain policy, weights and vitals summary, PSWs, RN, Physiotherapist and other staff. [s. 6. (11) (b)]

An order was made by taking the following factors into account:

Severity: Resident #001 demonstrated signs and symptoms of unrelenting pain and disability, no new approaches to care were considered.

Scope: This was an isolated case as there were no other incidents related to plan of care not being revised with new approaches.

Compliance History: In the last 36 months, the licensee was found to be non compliant with different sub-sections of the legislation and 36 other COs were issued to different sections of the legislation, all of which have been complied. (532)

**This order must be complied with by /**

**Vous devez vous conformer à cet ordre d'ici le :**

Dec 03, 2020

**Order(s) of the Inspector**

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

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
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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

**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:

**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

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](http://www.hsarb.on.ca).

**Order(s) of the Inspector**

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

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2007, c. 8

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l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

**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, 11<sup>e</sup> étage  
Toronto ON M5S 2B1  
Télécopieur : 416-327-7603

**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

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l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

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 révision  
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](http://www.hsarb.on.ca).

**Issued on this 4th day of November, 2020**

**Signature of Inspector /**

**Signature de l'inspecteur :**

**Name of Inspector /**

**Nom de l'inspecteur :** Nuzhat Uddin

**Service Area Office /**

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