Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: June 3, 2024	
Inspection Number: 2024-1114-0003	
Inspection Type: Critical Incident	
Licensee: Caressant-Care Nursing and Retirement Homes Limited	
Long Term Care Home and City: Caressant Care Fergus Nursing Home, Fergus	
Lead Inspector Bernadette Susnik (120)	**Inspector Digital Signature** Bernadette Susnik Digitally signed by Bernadette Susnik Date: 2024.06.10 10:53:50 -04'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 23, 2024

The following intake was inspected:

- Intake: #00107881 related to a critical incident of staff to resident neglect.

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

Safe and Secure Home

INSPECTION RESULTS

WRITTEN NOTIFICATION: Doors in a home

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 12 (1) 1. iii. A.

Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
iii. equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or

The licensee failed to ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that precluded exit by a resident, including balconies and terraces, or doors that residents had access to were connected to the resident-staff communication and response system (RSCRS).

Rationale and Summary
Two doors leading to an unsecured outdoor area from the home and two doors leading to stairways in the home, all of which were accessible to residents, were not connected to the RSCRS. When the doors were unlocked and held open to activate any alarms, the location of the doors did not display on the desk console located at the nurse's station closest to the door used by staff to determine the location of the breached doors. When the RSCRS was replaced with a new system in April 2019, the licensee did not ensure that the installer connected the above noted doors to the RSCRS.

Sources: Testing of the doors, interview with the Director of Building Operations, review of the "Call Bell - Resident" policy S12-10.0. [120]

WRITTEN NOTIFICATION: Communication and response system

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 20 (g)

Communication and response system
s. 20. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff.

The licensee failed to ensure that the home was equipped with a resident-staff communication and response system (RSCRS) that in the case of a system that used sound to alert staff, was properly calibrated so that the level of sound was audible to staff.

Rationale and summary

The licensee commissioned a contractor to install a new RSCRS in April 2019 at which time an insufficient number of audio speakers were added to ensure that the sound was equally calibrated throughout the home area (entire second floor).

The north hall near the lounge and the central hall near the exit to the outdoor deck did not have any other sound source except for the desk console at each of the two nurse's stations. The desk console had buttons on it that could be used by staff to lower or increase the volume of the sound. Even at its highest setting, the beeping sound that emanated from the desk console when a call station was activated, could not be heard when standing in the two different hall areas. Competing noises from air cleaners, air conditioners running and individuals speaking drowned out the sound.

An inquiry conducted with the Director of Care on February 8, 2024, revealed that no audible alert could be heard when two call stations were activated. Beginning on

February 13, 2024, a maintenance employee advised that the issue was being addressed and that an additional speaker would be installed. By May 13, 2024, the speaker had not been installed. As of the date of the inspection, one speaker had been ordered and was pending delivery and installation.

Sources: Interview with the Director of Building Operations, maintenance employee, review of correspondence and purchase order from the equipment supplier, testing of the RSCRS. [120]

WRITTEN NOTIFICATION: Maintenance services

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 96 (1) (b)
Maintenance services
s. 96 (1) As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance.

As part of the organized program of maintenance services under clause 19 (1) (c) of the Act, the licensee failed to ensure that there were schedules and procedures in place for routine, preventive and remedial maintenance.

In accordance with O. Reg 246/22 s. 11 (1) (a), the licensee is required to implement any schedules and procedures that are to be in place for routine, preventive and remedial maintenance. Specifically, the licensee did not implement their policy "Call Bell - Resident" dated January 29, 2024, and revised April 12, 2024.

Rationale and Summary
During the inspection, approximately five call station pull cords were missing and approximately five became easily dislodged from the receptacle housing when

pulled. A push button at the end of a call cord for a bed in and identified resident room did not trigger an alert.

A review of the Maintenance Care system that staff used to report equipment malfunctions and deficiencies included four reports between January 1 and May 23, 2024. All four included reports for missing call cords.

None of the doors leading to stairwells or to unsecured outdoor areas to which residents had access had a functioning door alarm. The alarms were noted to be of the type that could be stuck onto a door frame or surface of the door.

The licensee's policy for maintaining the resident staff communication and response system (RSCRS) or the call bell system as identified by the licensee's policy, required an audit be conducted of each call station quarterly. The audits required the maintenance person or designate to check the ceiling lights, the cords, the display at the nurse's station desk console and the sound. The same policy also included that an audit be conducted of the door alarms to ensure that the location of the door was displayed at the nurse's station and that it rang. No audits were completed in 2024 or 2023.

Sources: Testing of the RSCRS, review of the "Call Bell - Resident" policy S12-10.0, maintenance care reports, and existing audits, interview with the Director of Building Operations, random care staff, and residents. [120]

WRITTEN NOTIFICATION: Construction, renovations, etc., of homes

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 356 (3) 2.
Construction, renovation, etc., of homes
s. 356 (3) A licensee may not commence any of the following work without first receiving the approval of the Director:

2. Other work on the home or work on its equipment, if doing the work may significantly disturb or significantly inconvenience residents.

The licensee failed to receive the approval of the Director before commencing work on its equipment which may have significantly inconvenienced residents.

Rationale and Summary
The licensee installed a new resident-staff communication and response system in April 2019. No work plan or specifications describing how the work would be carried out, including how residents would be affected and what steps were to be taken to address any adverse effects on residents was submitted.

When installed, the contractor was required to run new wiring externally and install new call stations to each resident room, resident washroom, common space, and bathing areas. This process required contractors to be on site for over a week, spending over an hour in each resident bedroom and washroom thereby requiring residents to be out of their rooms while the work was being performed. For some residents, the presence of contractors and having to stay out of their rooms for a period of time may contribute to certain behaviours and therefore could have caused them significant inconvenience.

Sources: Interview with the Director of Building Operations, and observations of the new RSCRS. [120]