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

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Original Public Report

Report Issue Date: October 14, 2022	
Inspection Number: 2022_1108_0001	
Inspection Type: Critical Incident System	
Licensee: Caressant-Care Nursing and Retirement Homes Limited	
Long Term Care Home and City: Caressant Care Harriston, Harriston	
Lead Inspector Katherine Adamski (#753)	**Inspector Digital Signature** Katherine Adamski Digitally signed by Katherine Adamski Date: 2022.10.14 13:53:49 -04'00'
Additional Inspector(s) N/A	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
October 3-7, 11-12, 2022

The following intake(s) were inspected:

- Intake: #00004166 - related to fall prevention and management
- Intake: #00004654 - related to falls prevention and management
- Intake: #00004846 - related to responsive behaviours management
- Intake: #00007645 - related to responsive behaviours management

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

Infection Prevention and Control
Falls Prevention and Management
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: BEHAVIOURS AND ALTERCATIONS

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 60 (a)

The licensee failed to ensure that, (a) procedures and interventions were developed and implemented to assist residents who were at risk of harm or who were harmed as a result of a resident's behaviors, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents #003, #004, #005 and #006.

Rationale and Summary

a) Resident #003 had responsive behaviours in predictable situations related to identified triggers. Resident #003's plan of care included interventions for managing their responsive behaviours. Resident #004 also had responsive behaviors which were a potential trigger for resident #003.

Resident #003 and #004 were in close proximity to each other without active supervision from staff. Resident #003 became triggered by resident #004 and expressed responsive behaviours. As a result, resident #004 was physically injured.

When procedures and interventions were not implemented to minimize the risk of altercations between resident #003 and others, resident #004 was physically injured.

Sources: Resident #003's care plan with revision history, progress notes related to the incident, medication orders, resident #004's plan of care including care plan, skin and wound assessments and progress notes, interviews with the BSO Lead and other staff.

b) Resident #006 had responsive behaviors and interventions for managing their behaviours.

Resident #006 and resident #005 had an altercation related to resident #006's responsive behaviours resulting in an injury to resident #006.

After the incident, resident #006 continued to express responsive behaviours, and staff stated that their current interventions for managing them were not effective.

When procedures and interventions were not implemented to minimize the risk of altercations between resident #005 and #006, resident #006 was injured.

Sources: Resident #006's care plan with revision history, progress notes related to the incident, resident #005's care plan with revision history, progress notes related to the incident, interviews with the BSO Lead and other staff.

WRITTEN NOTIFICATION: PLAN OF CARE

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

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 related to fall prevention interventions.

Rationale and Summary

Resident #001 had a fall resulting in an injury. In response to this fall, resident #001's plan of care was reviewed and revised to include specific fall prevention interventions.

Since this time, resident #001 has had subsequent falls, including two which occurred when their fall prevention interventions were not implemented by staff.

The home's Fall Program Lead acknowledged that staff were not following resident #001's plan of care at the time of the falls.

When resident #001's care was not provided as specified in their plan of care, this put resident #001 at risk for further falls and subsequent injuries.

Sources: Resident #001's plan of care including kardex, care plan with revision history, progress notes, post fall assessments, interviews with the home's Falls Program Lead and other staff.

WRITTEN NOTIFICATION: INFECTION PREVENTION AND CONTROL

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 23 (4)

The licensee has failed to ensure that the home had an infection prevention and control (IPAC) Lead whose primary responsibility was the home's IPAC program.

Rationale and Summary

The home's Resident Care Co-Ordinator (RCC) who was also the home's designated IPAC and Falls Program Lead stated that their primary responsibility in the home was as the RCC. The RCC stated that they dedicated approximately 12 to 20 hours per week, to IPAC related tasks. The Administrator acknowledged that the home did not have an IPAC Lead whose primary responsibility was the home's IPAC program. The Administrator stated that Head Office was aware of the requirements for the IPAC Lead, however they were unaware of the plans for recruitment.

During the inspection, concerns were identified related to a Personal Support Worker not encouraging and/or assisting residents to sanitize their hands before providing them with a snack.

When the home did not have an IPAC Lead whose primary responsibility was the home's IPAC program, this may contribute to inadequate oversight of staff's provision of IPAC practices.

Sources: Observations, interviews with the Administrator and other staff.

[#753]