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

Public Report

Report Issue Date: February 5, 2025

Inspection Number: 2025-1108-0001

Inspection Type:
Critical Incident

Licensee: Caressant-Care Nursing and Retirement Homes Limited

Long Term Care Home and City: Caressant Care Harriston, Harriston

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 23 - 24, 28, 30-31, 2025 and February 3- 5, 2025
The inspection occurred offsite on the following date(s): January 29, 2025
The following intake(s) were inspected:

- Intake: #00133964 - Resident to resident physical abuse.
- Intake: #00134992 - Staff to resident alleged abuse.
- Intake: #00135162 - Resident to resident physical abuse.
- Intake: #00137473 - Missing resident less than three hours.

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

Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee has failed to protect resident #002 and #003 from physical abuse by resident #001 on two separate occasions resulting in injuries to resident #002 and #003.

Section 2 of O. Reg., 246/22, defines "physical abuse" as the use of physical force by a resident that causes physical injury to another resident.

Source: Observations, medical record review of resident #001 and #002, interview with PSW#101 and other staff.

COMPLIANCE ORDER CO #001 Altercations and other interactions between residents

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 59 (b)
Altercations and other interactions between residents
s. 59. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(b) identifying and implementing interventions.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1. Conduct an interdisciplinary assessment of resident #001 and #002 to:

a) identify factors that could potentially trigger their responsive behaviours

b) Develop written processes and implement specific interventions to minimize the risk of altercations and potentially harmful interactions between resident #001 and resident #002 and other residents.

c) Develop a plan in place for when one to one (1:1) supervision staff leave the resident for their break or do not show up for their shift.

2. Ensure that resident #001 and #002's interventions are reevaluated when changes are made to their plan of care related to their responsive behaviours.

3. Ensure the above steps 1 to 2 are documented, including the individuals who participated in the interdisciplinary assessment, the date, the discussion and the outcome. All triggers, interventions and reassessments should also be documented.

4. Educate Registered Practical Nurse (RPN) #105 and #106 on the following policies:

a) CODE WHITE – Violent Person- P and P
b) Responsive Behaviour Care Pathway

5. Document the date of the re-training, names of the staff members who provided and received the training.

Grounds

A) The licensee has failed to ensure that steps were taken to minimize the risk of a physical altercation between residents #001 and #003.

During an incident where resident #001 was agitated and verbally expressive towards staff and residents, staff were unable to redirect the resident. However, they did not take additional steps to ensure the safety of other residents. As a result, resident #001 caused injury to resident #003.

Resident #003 sustained an injury, and other residents were put at risk for potentially harmful interactions with resident #001 when steps were not taken to minimize the risk of altercations.

Sources: Observations, Medical record review of resident #001 and #003, interview with Director of Care (DOC) and other staff.

B) The licensee has failed to ensure that steps were taken to minimize the risk of physical altercations between residents #001 and #002.

When resident #002's intervention for the management of responsive behaviours was not in place, an altercation occurred between resident #001 and #002 where resident #002 received an injury.

Source: Observations, review of medical record for resident #001 and #002, interview with Director of Care (DOC) and other staff.

This order must be complied with by March 19, 2025

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REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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