

Ministry of Long-Term Care

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

London District

130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: January 3, 2024	
Inspection Number: 2023-1226-0006	
Inspection Type: Critical Incident	
Licensee: Caessant-Care Nursing and Retirement Homes Limited	
Long Term Care Home and City: Caessant Care on Bonnie Place, St Thomas	
Lead Inspector Julie Lampman (522)	Inspector Digital Signature
Additional Inspector(s)	

INSPECTION SUMMARY

<p>The inspection occurred onsite on the following date(s): December 13, 14, 15, and 18, 2023.</p> <p>The following intake(s) were inspected:</p> <ul style="list-style-type: none"> • Intake: #00101194/Critical Incident System (CIS) report related to falls prevention and management. • Intake: #00102267/CIS related to staff to resident neglect

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

- Infection Prevention and Control
- Falls Prevention and Management
- Prevention of Abuse and Neglect

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INSPECTION RESULTS

WRITTEN NOTIFICATION: Required Programs

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

Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.

Required programs

s. 53 (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The licensee has failed to comply with the home's falls prevention and management policy related to assessing a resident post fall, included in the required falls prevention and management program in the home.

Rationale and Summary

In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee was required to ensure that written policies and protocols were developed for the falls prevention and management program and ensure they were complied with.

Specifically, staff did not comply with the licensee's "Fall Management Program-Post Fall Management Procedure" policy #LTC-NURSS10-40.0 last reviewed September 18, 2023, related to assessing a resident post fall.

The home's "Fall Management Program-Post Fall Management Procedure" policy stated, "Upon discovery of a fall the registered staff will initiate a Post Fall Investigation Assessment at the bedside for the resident (for all witnessed and unwitnessed falls) then transcribe findings into the post fall investigation document

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in PCC. The electronic assessment will guide the assessment of the Resident (see- Post Fall Investigation Assessment in PCC)."

Review of the home's Post Fall Investigation Assessment in Point Click Care (PCC) noted that staff were to assess the resident and document the 'most recent' assessments.

The resident had thirteen falls over the course of four months in 2023. In the resident's post fall assessments staff did not assess a specific area as required and entered information from 2022.

The Nurse Practitioner (NP) stated registered staff should have assessed the resident as per the post fall assessment. The NP stated when they reviewed one of the resident's post fall assessments, they caught that staff had not been assessing a specific area as required by the post fall assessment and staff had entered information from 2022, where the assessment required a 'most recent' assessment. The NP stated they spoke with staff regarding this and wrote an order to complete the specific assessment for the resident post fall.

By not completing the required assessment post fall, there was risk that staff might have missed contributing factors to the resident's falls.

Sources:

The resident's clinical records, the home's "Fall Management Program-Post Fall Management Procedure" policy #LTC-NURSS10-40.0 last reviewed September 18, 2023, and interviews with the NP and other staff. [522]

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COMPLIANCE ORDER CO #001 Duty to protect

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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

Specifically, the licensee must ensure:

A) A staff member receives retraining on the home's prevention of abuse and neglect policy and resident rights.

B) The staff member receives training on signs and symptoms of a specific diagnosis.

C) A record must be kept of the training, including the contents of the training, the date of the training, and the name of the trainer.

Grounds

The licensee has failed to ensure that a resident was not neglected by a staff member.

Rationale and Summary

O. Reg 246/22 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents."

A Critical Incident System (CIS) report was submitted by the home to the Ministry of

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Long-Term Care. The CIS report indicated that a resident was neglected by a staff member.

The resident stated they were unwell and a staff member failed to provide them with assistance. The resident stated due to this they were fearful of the staff member.

The Director of Care (DOC) stated the staff member had neglected the needs of the resident and that there could have been a poor outcome for the resident.

There was actual risk to the resident when the staff member neglected their needs, because of this the resident was fearful of the staff member.

Source:

A CIS report, the resident's clinical record, the home's investigation records, the staff member's employee file, the home's Zero Tolerance of Abuse and Neglect Policy LTC" last reviewed November 2023, and interviews with the resident, the DOC and other staff. [522]

This order must be complied with by January 17, 2024

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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

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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:



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

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Health Services Appeal and Review Board

Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director

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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.