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

London District
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Original Public Report

Report Issue Date: November 6, 2023	
Inspection Number: 2023-1136-0002	
Inspection Type: Critical Incident	
Licensee: Caressant-Care Nursing and Retirement Homes Limited	
Long Term Care Home and City: Caressant Care on Mary Bucke, St Thomas	
Lead Inspector Pauline Waldon (741071)	**Inspector Digital Signature** Pauline Louise Waldon Digitally signed by Pauline Louise Waldon Date: 2023.11.16 11:42:45 -05'00'
Additional Inspector(s)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 23 - 25, 27, 30, 31, 2023 and November 1, 2023.

The following intake(s) were inspected:

- Intake: #00097124 - CIS: 2627-000022-23: Related to falls prevention and management
- Intake: #00098258 - CIS: 2627-000023-23: Related to an outbreak

The following intakes were completed in this inspection:

- Intake: #00093762 (CIS: 2627-000017-23), Intake: #00095593 (CIS: 2627-000019-23), Intake: #00096478 (CIS: 2627-000020-23), and Intake: #00096816 (CIS: 2627-000021-23) related to falls prevention and management.

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

Infection Prevention and Control
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care: When reassessment, revision is required

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)

The licensee failed to ensure that when a resident developed new signs and symptoms of a disease process, that their plan of care was revised to monitor the signs and symptoms.

Rationale and Summary:
Progress notes indicated that a resident developed new signs and symptoms of a disease process and was assessed by the Nurse Practitioner (NP) due to these the following day. In a review of the resident's electronic health care record, there was no documentation to support the resident's signs and symptoms had been monitored since seeing the NP.

The Director of Care (DOC) stated that they would have expected registered staff to monitor the resident.

There was risk that the resident did not receive the care required because the plan of care was not revised to include the monitoring of the resident’s new signs and symptoms.

Sources: Resident's progress notes, electronic health record, and interview with the DOC.

[741071]

WRITTEN NOTIFICATION: Plan of Care: Documentation

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (9) 2.

The licensee failed to ensure that the outcome of the care set out in the resident's plan of care was documented.

Rationale and Summary:
A resident was assessed by the NP for new signs and symptoms of a disease process. The resident was

ordered a medication to treat the signs and symptoms which was to be reassessed after the completion of a test to rule out the disease process. The test was completed 11 days later.

There was no indication in the progress notes or the medical orders that the resident was reassessed by the NP once the test was completed.

The NP reported that they reassessed the resident although they failed to document the reassessment.

By failing to document the outcome of the resident's plan of care, there was risk that direct care staff would not provide the care required to manage the resident's signs and symptoms effectively.

Sources: Resident's progress notes, medical orders, and interview with the NP.

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WRITTEN NOTIFICATION: Infection Prevention and Control

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (9) (b)

The licensee failed to ensure that immediate action was taken to assess and isolate a resident to reduce the risk of disease transmission.

Rationale and Summary:
A resident presented with signs and symptoms of an infection, but was not assessed for the infection and placed on additional precautions until the following day.

The Infection Prevention and Control (IPAC) Lead stated that an assessment should have been done on the day the resident presented with the signs and symptoms of infection.

On a separate occasion, the same resident left the home for additional medical care and returned the same day. The home received a form stating that the resident had testing done during this absence with results pending. The home was notified two days later of the test results, at which time the resident was placed on additional precautions.

The IPAC Lead stated that when the resident returned to the home, they should have been placed on additional precautions pending the test results.

There was risk of disease transmission when the home failed to assess and take immediate action to isolate the resident when required.

Sources: Resident's progress notes, MAR, Resident Transfer Back to Nursing Home form, interview with the IPAC Lead.

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WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (1) 5.

The licensee failed to ensure that the Director was immediately informed when the home was in a confirmed outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Rationale and Summary:
A Critical Incident Report (CIS) for an outbreak was not submitted to the Ministry until the day after it was declared.

The Executive Director (ED) acknowledged the report was late.

There was no risk to the residents because of the late reporting.

Sources: CIS: 2627-000023-23, interview with ED.

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