Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 21, 2020	2020_643111_0012	024460-19, 002096-20, 003191-20, 005355-20, 009866-20	Critical Incident System

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue WOODSTOCK ON N4S 3V9

Long-Term Care Home/Foyer de soins de longue durée

Caressant Care on McLaughlin Road
114 McLaughlin Road LINDSAY ON K9V 6L1

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): July 21, 22, 23, 24, 27, 2020 and July 28, 2020 (off-site).

The following critical incident inspections were completed concurrently during this inspection:
-one CIR related to alleged neglect of a resident.
-three CIR's related to falls with an injury.
-one CIR related to an injury of unknown cause.

An inspector initiated inspection was also completed during this inspection related to Infection Prevention and Control.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), acting Director of Care (a-DOC), Resident Care Coordinator (RCC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), RAI Coordinator, Physiotherapist (PT), Physiotherapy Assistant (PTA), Restorative Care Aide (RCA), Housekeepers, students and residents.

During the course of the inspection, the inspector: observed residents, reviewed resident health care records, observed infection prevention and control practices, reviewed falls preventions meeting minutes, reviewed the Infection Prevention and Control Assessment, reviewed complaints and reviewed the following policies-pain management, falls prevention, prevention of abuse and neglect.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Pain
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

7 WN(s)
4 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

The licensee has failed to ensure that if the resident is being reassessed and the plan of care is being revised, because care set out in the plan has not been effective, different approaches have been considered in the revision of the plan of care.

Critical incident report (CIR) was submitted to the Director for a fall for which the resident was taken to hospital and which resulted in a significant change in condition. The CIR indicated on a specified date and time, resident #004 sustained an un-witnessed fall, was subsequently transferred to hospital for assessment and was diagnosed with an injury to a specified area. The CIR indicated the resident had a history of falls.

Review of the progress notes for resident #004 indicated, the resident sustained a number of falls, within a specified period, one resulting in an injury to a specified area (CIR). The resident also sustained a near miss incident with a Personal Assistive Safety Device (PASD). The progress notes indicated specific falls prevention interventions were not implemented until after the resident returned from hospital and after a number of falls had occurred. Staff had recommended on more than one occasion, a specified intervention to allow staff to respond more quickly to a fall, but was not implemented until after a number of falls occurred. The resident was also inconsistently placed on varied monitoring intervals. The use of a PASD continued for a specified period, despite demonstrated ineffectiveness and after a near miss incident. A new falls prevention intervention was not considered until after the last fall.

Review of the written plan of care for resident #004 (completed on a specified date) related to risk for falls, indicated that specified interventions were not identified until after

a number of falls occurred.

During an interview with the Executive Director (ED), they indicated when a resident sustained a fall, the expectation is for the registered staff to complete the post fall investigation tool and the risk management report, which should include actions taken to prevent a recurrence. The ED indicated the registered staff should also update the resident's care plan. The ED indicated the home also had an interdisciplinary Safety Committee that met monthly to discuss residents that have fallen and preventative measures to be put in place. The ED indicated the meetings had not occurred monthly since the pandemic and resident #004 would not have been discussed at that time.

The licensee failed to ensure the plan of care was reviewed and revised when the interventions were determined to be ineffective, as the resident continued to fall and sustained an injury to a specified area. In addition, the use of the PASD was also shown to be ineffective and had a near miss incident. No other interventions were considered, until after another fall occurred.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure care is provided to residents based on the resident's assessed needs and preferences, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

The licensee has failed to ensure that any policy instituted or otherwise put in place is complied with.

Critical incident report (CIR) was submitted to the Director for an injury for which the resident was taken to hospital and which resulted in a significant condition. The CIR indicated on a specified date and time, resident #004 sustained an un-witnessed fall. The resident was subsequently sent to the hospital for assessment due to continued complaints of pain to a specified area and was diagnosed with an injury to a specified area.

Under O.Reg. 79/10, s.48(1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: 4. A pain management program to identify pain in residents and manage pain.

Review of the progress notes for resident #004 indicated on a specified date and time, the resident had sustained a fall and complained of pain to a specified area. The resident was receiving routine pain medication and was given an as needed (PRN) pain medication for complaints of pain with poor effect. Throughout the following day, the resident had additional injuries noted post fall and continued to complain of pain to the specified area, despite the pain medication provided. The staff confirmed the pain management was not effective, contacted the physician and the resident was transferred to hospital. The resident returned from hospital on a specified date, diagnosed with an injury to a specified area and with a new PRN pain medication. The resident had ongoing complaints of pain to the specified area, demonstrated ongoing responsive behaviours and had started physiotherapy. The resident was given anti-anxiety and pain medication at the same time periodically, with good effect. The BSO staff indicated the resident's pain management needed to be reviewed, as the pain medication was not given frequently enough and may have been contributing to the responsive behaviours.

There was no pain assessment completed when the injury occurred post fall, when the resident returned from hospital and when a new pain medication was started as per the policy. There was no pain management flow sheet completed to evaluate the effectiveness of the pain management, as per the pain management policy. The pain assessment was not completed until a number of days after the resident returned from hospital.

During an interview with RPN #100, they confirmed awareness of resident #004 sustaining a fall the day before they came to work and they noted the resident was complaining of severe pain to a specified area. The RPN indicated the DOC informed them that no residents were being sent to the hospital at that time but they insisted that the resident needed to be assessed and called the physician. The RPN indicated the physician gave the order to transfer the resident to the hospital. The RPN confirmed the resident was in a significant amount of pain.

The licensee had failed to ensure that the pain policy had been complied with as after resident #004 sustained a fall, they continued to complain of ongoing, severe pain for a number of days. A pain assessment had not been completed and there was no consultation with the physician or NP for increased pain medication as required by the policy. When the resident returned from the hospital with an injury to a specified area with a new pain medication, a pain assessment had not been completed as required by the policy. When the resident began physiotherapy and began exhibiting responsive behaviours, that may have indicated pain, a pain assessment was not completed, as required by the policy and the pain assessment had not been completed until a number of days later. The Pain Management Flow Sheet was also not considered to assist with the assessment and evaluation of pain management, as per the policy.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the pain policy instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

The licensee has failed to ensure that they immediately forwarded any written complaints that have been received concerning the care of a resident or the operation of the home to the Director.

Critical incident report (CIR) was submitted to the Director for an injury that resulted in transfer to hospital and a significant change in condition. The CIR indicated on a specified date that staff noted resident #002 had an injury to a specified area. A number of days later, the resident had an in-house diagnostic test completed A number of days later, the test revealed an injury to a specified area.

During an interview with the ED, they indicated a written complaint (via email) from the family of resident #002 was received regarding the incident. The ED confirmed that the written complaint was not provided to the Ministry of Long Term Care (MLTC).

The written complaint from the family of resident #002 was submitted to the home on a specified date and indicated concerns with care and treatment provided to resident #002 related to the incident.

The licensee had failed to ensure that they immediately forwarded a written complaint from the family of resident #002 concerning the care of a resident, to the Director.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that they immediately forwarded any written complaints that have been received concerning the care of a resident or the operation of the home to the Director., to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program (IPAC).

During observations by the Inspector on specified dates and at various times, the Inspector observed ongoing practices where staff were not participating in the implementation of the IPAC program. The following IPAC concerns were observed/identified:

1. On a date in July 2020, upon entering the front entrance, the screener completing the active screening of all visitors was wearing a mask and a gown but no eye protection. Upon exiting the home, the Inspector was not actively screened, despite a different screener being present. This screener was wearing a mask and no other PPE. The DOC was also observed at various times throughout the day wearing their mask just under their nose (incorrectly applied).

2.The following day, upon arrival to the home, the Inspector observed a number of staff sitting outside near the parking lot, not physically distancing of six feet apart and not wearing masks. Upon entering the main entrance of the home, a screener was wearing a mask and no other PPE. The screener did not complete the full screening (only obtained the Inspectors temperature and did not ask any screening questions).

On unit 1: resident #006 and resident #007 had a Personal Protective Equipment (PPE) station just outside of their rooms (included masks, gowns, gloves and hand sanitizer). There was no disinfectant wipes or signage available to indicate the type of isolation precaution in place or PPE to be used. Resident #008 had a PPE station just outside of their room (included masks, gowns, gloves and hand sanitizer). The sign posted on the resident’s door indicated specified precautions. There was no eye protective wear or disinfectant wipes available.

PSW #106 was observed by the Inspector, entering resident #008's room while wearing a mask and no other PPE despite being on a specified precautions. The resident was not

in the room at the time but the PSW was observed touching the resident's personal items, then exited the resident’s room without performing hand hygiene and then entered resident room #022, without performing hand hygiene.

During an interview with PSW #106, they indicated resident #006 and #007 were on contact precautions for specified diagnosis. The PSW indicated that resident #008 was on identified precautions for 14 days. The PSW confirmed that there should be signage posted for anyone on isolation to indicate which type of precautions is in place and PPE to be used. The PSW was not aware that they were to be using protective eye wear when entering resident #008's room and confirmed that there was no protective eye wear or disinfectant wipes available for use at the PPE station provided.

On Unit 2: resident #010 had a PPE station just outside of their room. There was no visible signage to indicate the type of isolation precautions the resident was on. The specified precaution sign was located laying on top of the PPE station (which is approximately over five feet high and not clearly visible.

A housekeeper (HSK #108) was observed cleaning resident room #217 while wearing gloves and a mask. The HSK confirmed awareness of specified precautions in place for room #217 and should be wearing a gown, gloves and a mask when cleaning the room. The HSK confirmed no awareness that they were also to be wearing eye protection and confirmed they also did not wear any eye protection when cleaning the room.

On Unit 3: resident #011 had a PPE station outside their room that contained virox wipes, gloves, masks, gowns and hand sanitizer. There was no signage available to indicate the type of specified precautions the resident was on and there was no eye protective wear available.

Review of the licensee's policy "Infection Prevention & Control Coordinator" (reviewed May 2019) indicated under #10, the IPAC Coordinator monitors staff adherence to protocols such as proper hand hygiene, isolation practices and screening.

During an interview with the Resident Care Coordinator (back-up IPAC Nurse), they indicated resident #011 was on specified precautions. They confirmed there was no signage or eye protective wear available and should have been. The RCC also indicated that all residents on specified precautions should have signs posted at entrance of the rooms that are clearly visible. The RCC confirmed that there should also be eye protective wear and disinfectant wipes available for those residents on specified

precautions. The RCC confirmed they did not have any donning/doffing signage available and did not complete any IPAC audits in the home.

3. The following day, the Inspector was not screened upon exiting the home. The screener set up inside the home was wearing a mask and no other PPE.

4.The following day, upon arrival to the home, the Inspector observed a number of staff sitting outside near the parking lot, not physically distancing six feet apart or wearing a mask. Upon entering the home, the screener did not actively screen the Inspector.

During an interview with staff #118 (screener), upon exit of the home, they indicated that all staff are required to complete the COVID screening tool upon entry/exit of the home and included having their temperatures checked. They indicated that all families and visitors are to be actively screened and asked the same questions that staff are to complete, as well as their temperatures checked and recorded on the visitor logs. Staff #118 did not complete the active screen with the Inspector.

5. A number of days later, upon entry to the home, the Inspector observed the screener wearing a mask and no other PPE. The screener completed a temperature check and only asked the Inspector if they were unwell. There were no other screening questions asked.

During an interview with the screener (staff #118) by the Inspector, upon exiting the home, they indicated that all staff and visitors are required to complete the COVID active screening tool upon entry to the home and included a temperature checked. They indicated that all families and visitors are to be actively screened and asked the same questions that staff are to complete, as well as their temperatures checked and recorded on the visitor logs. The screener did not complete the active screen with the Inspector.

On unit 1: resident #012 had a PPE station outside of their room (that contained masks, gowns, gloves and hand sanitizer). There were no disinfectant wipes available and no signage visible to indicate the type of isolation precautions in place or which PPE was to be used.

Review of the home’s IPAC Assessment identified the same concerns. The assessment also recommended that audits be completed to ensure appropriate supply of PPE at point of care outside the resident rooms and staff performing physical distancing.

The infection prevention and control program is required to include measures to prevent the transmission of infections as per s.86(1)(b) under the LTCH Act. Measures to prevent the transmission of infections include but are not limited to proper screening of staff and visitors, hand hygiene, visible notification of precautions and PPE required when entering a resident room, appropriate donning and doffing of personal protective equipment (PPE), and physical distancing. The licensee failed to ensure that staff participated in implementing these measures to minimize or prevent the transmission of infections.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

The licensee has failed to ensure that when the resident has fallen, the resident been assessed and, if required, a post-fall assessment had been conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Critical incident report (CIR) was submitted to the Director for a fall incident that resulted in transfer to hospital and resulted in a significant change in condition. The CIR indicated on a specified date and time, resident #001 sustained an un-witnessed fall in a specified area. The resident complained of pain to specified areas and was transferred to hospital for assessment. The CIR indicated the resident had a history of falls.

During an interview with the Executive Director (ED), they indicated when a resident sustained a fall, the expectation was for registered staff to complete the paper copy of the safety plan-post fall investigation tool.

Review of the progress notes for resident #001 indicated the resident had sustained a number of four falls on specified dates.

Review of the post fall assessments for resident #001 indicated the safety plan-post fall investigation was not completed for a number of the falls identified.

The licensee failed to ensure that when resident #001 had fallen, the resident had been assessed using the safety plan post fall investigation as required.

2. Critical incident report (CIR) was submitted to the Director, for a fall for which the resident was taken to hospital and which resulted in a significant change in condition. The CIR indicated on a specified date and time, resident #004 sustained an un-witnessed fall in a specified area and complained of pain to a specified area. The following day, the resident continued to complain of pain, had reduced mobility and was transferred to hospital for assessment. The resident was diagnosed with an injury to a specified area.

Review of the progress notes for resident #004 indicated the resident had sustained a number of falls during a specified area.

Review of the safety plan-post fall investigation tools for resident #004 indicated there was no post fall assessments completed for a specified number of the falls.

The licensee failed to ensure that when resident #004 had fallen, the resident had been assessed and the post-fall assessment (safety plan post fall investigation) had been conducted as required.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

The licensee has failed to ensure that all hazardous substances labelled properly and kept inaccessible to residents at all times.

During an observation by the Inspector at a specified time and on a specified unit, related to infection control in the home, the Inspector observed a clean utility room door was propped open with two full jugs of body wash on the floor. On the counter there was a bottle of disinfectant and a bottle of shampoo. They all contained symbols that indicated they were hazardous substances.

During an interview with PSW # 117, they indicated that they found the room propped open, they did not know who propped it open and never should be propped open due to hazardous substances accessible to residents.

During an interview with the ED, they confirmed that staff should not be propping open utility rooms where hazardous substances are accessible to residents.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

The licensee has failed to ensure that every written or verbal complaint made to the

licensee or a staff member concerning the care of a resident or operation of the home has been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation commenced immediately.

Critical incident report (CIR) was submitted to the Director for an injury that resulted in transfer to hospital and a significant change in condition. The CIR indicated on a specified date that staff noted resident #002 had an injury to a specified area. A number of days later, the resident had an in-house diagnostic test completed A number of days later, the test revealed an injury to the specified area.

The written complaint from the family of resident #002 was also submitted to the home indicating concerns with the care and treatment provided to resident #002, related to the incident.

During an interview with the ED, they indicated they received the written complaint from the family of resident #002 regarding the incident and confirmed that they had no documented investigation regarding the complaint.

2. Critical incident report (CIR) was submitted to the Director for suspected staff to resident neglect. The CIR indicated the family of resident #003 had verbally reported a complaint to the RCC on a specified date, regarding the care the home had been providing to the resident.

During an interview with the RCC, they indicated they received a verbal complaint from the family of resident #003 during their care conference and documented the family's concerns in the residents progress notes. The RCC indicated they attempted to resolve the family's concerns and encouraged the family to put their concerns in writing, as they had many concerns. The RCC indicated they informed the ED and DOC of the family's concerns. The RCC indicated they assumed the ED or DOC would have followed up with the family.

Review of the progress notes for resident #003 indicated the verbal concerns by the family were reported to the RCC and DOC on a specified date, during a care conference. The family identified a number of concerns and the DOC indicated they would follow-up with the family. The following day, the family remained dissatisfied and indicated they would lodge a complaint with the Ministry. A number of days later, the family again reported a number of concerns to the RCC, the RCC asked if they wanted to file an

official complaint and then asked the family to put their concerns in writing. A number of days later, the family again reported their concerns to RN #119 and the RN provided a plan going forward, to resolve the family's concerns.

Review of the home's complaints indicated a complaint form was completed by the RCC, on a number of days after the initial verbal complaint was received. The complaint form indicated the family had a number of concerns identified related to resident care. The form indicated the ED met with the family to discuss their concerns, there was a detailed description by the ED of the families concerns and indicated a written complaint was never received. There was no indication of an investigation or a follow-up response to the family of the outcome of the investigation.

A verbal complaint that was received on a specified date by the family of resident #002, had no indication of an investigation completed or to indicate a response provided to the family within 10 days of receiving the complaint.

Issued on this 31st day of August, 2020

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.