Ontario

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

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

Central East District
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

Original Public Report

Report Issue Date: September 26, 2024	
Inspection Number: 2024-1400-0002	
Inspection Type: Complaint Critical Incident Follow up	
Licensee: Caressant-Care Nursing and Retirement Homes Limited	
Long Term Care Home and City: Caressant Care on McLaughlin Road, Lindsay	
Lead Inspector The Inspector	**Inspector Digital Signature**
Additional Inspector(s) The Inspectors	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): September 9-13 and 16-20, 2024

The following intake(s) were inspected:
- Intake: #00084687 - related to an allegation of abuse.
- Intake: #00085297 - related to improper care of a resident.
- Intake: #00096631 - related to an allegation of abuse.
- Intake: #00096803 - related to an allegation of abuse.
- Intake: #00096882 - related to an allegation of abuse.
- Intake: #00097546 - related to improper care of a resident.
- Intake: #00110864 - Complaint related to care concerns of a resident.

· Intake: #00117337 - Follow-up #1 - CO #009/ 2024-1400-0001, FLTCA, 2021 - s. 28 (1) 2. Reporting Certain Matters to the Director.
· Intake: #00117338 - Follow-up #1 - CO #001 / 2024-1400-0001, FLTCA s. 6 (1) (a) Plan of Care.
· Intake: #00117339 - Follow-up #2 - CO #001 / 2023-1400-0004, O. Reg 246/22 s. 147 (2) Medication incidents and adverse drug reactions, RIF $500.
· Intake: #00117340 - Follow-up #1 - CO #002 / 2024-1400-0001, FLTCA s. 6 (4) (a), Plan of Care.
· Intake: #00117341 - Follow-up #1 - CO #003 / 2024-1400-0001, FLTCA s. 24 (1) Duty to Protect.
· Intake: #00117342 - Follow-up #1 - CO #008/ 2024-1400-0001, FLTCA, 2021, s. 27 (1)(a) (i) Reporting and Complaints.
· Intake: #00117343 - Follow-up #1 - CO #005 / 2024-1400-0001, O. Reg s. 55 (2) (b) (ii) Skin and Wound Care.
· Intake: #00117344 - Follow-up #1 - CO #006 / 2024-1400-0001, O. Reg. 246/22 - s. 55 (2) (b) (iv), Skin and Wound Care,
· Intake: #00117345 - Follow-up #1 - CO #007/ 2024-1400-0001, O. Reg. 246/22 - s. 55 (2) (d), Skin and Wound Care,
· Intake: #00117346 - Follow-up #1 - CO #004 / 2024-1400-0001, O. Reg. 246/22 - s. 55 (2) (b) (i), Skin and Wound Care.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:

Order #009 from Inspection #2024-1400-0001 related to FLTCA, 2021, s. 28 (1) 2. inspected by the inspector
Order #001 from Inspection #2024-1400-0001 related to FLTCA, 2021, s. 6 (1) (a) inspected by the inspector

Order #001 from Inspection #2023-1400-0004 related to O. Reg. 246/22, s. 147 (2) inspected the inspector
Order #002 from Inspection #2024-1400-0001 related to FLTCA, 2021, s. 6 (4) (a) inspected by the inspector
Order #003 from Inspection #2024-1400-0001 related to FLTCA, 2021, s. 24 (1) inspected by the inspector
Order #008 from Inspection #2024-1400-0001 related to FLTCA, 2021, s. 27 (1) (a) (i) inspected by the inspector
Order #005 from Inspection #2024-1400-0001 related to O. Reg. 246/22, s. 55 (2) (b) (ii) inspected by the inspector
Order #006 from Inspection #2024-1400-0001 related to O. Reg. 246/22, s. 55 (2) (b) (iv) inspected by the inspector
Order #007 from Inspection #2024-1400-0001 related to O. Reg. 246/22, s. 55 (2) (d) inspected by the inspector
Order #004 from Inspection #2024-1400-0001 related to O. Reg. 246/22, s. 55 (2) (b) (i) inspected by the inspector

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

Skin and Wound Prevention and Management
Continence Care
Resident Care and Support Services
Medication Management
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Reporting and Complaints
Falls Prevention and Management

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 failed to protect a resident from abuse by staff.

Rationale and Summary

A critical incident system (CIS) report was submitted to the Director indicating an alleged witnessed incident of abuse.

The long-term care home's internal investigation notes indicated that a staff member heard yelling coming from a resident's room. When the staff entered the resident's room, they saw the resident's arms being held down by a registered staff during care for the resident. The resident continued to yell and attempt to refuse care.

The care plan indicated that the resident was resistive to care related to cognitive impairment. The care plan included an intervention, to leave and return in 5-10 minutes if the resident refused care.

The resident care coordinator (RCC) indicated a staff member heard yelling and saw the resident's arms held down during care. The staff member told the registered

staff involved that the resident had a right to refuse care, but the care continued. The RCC confirmed that the allegation of resident abuse was substantiated and that the expectation is for staff to stop and re-approach if a resident is refusing care.

Failing to protect a resident from abuse by staff risked the health and well-being of the resident.

Sources: CIS report, LTC home's internal investigation notes, clinical records for a resident, interview with RCC.

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee failed to ensure that it was immediately reported to the Director when there was a witnessed incident of resident abuse by staff.

Rationale and Summary

A critical incident system (CIS) report was submitted to the director indicating an alleged witnessed incident of abuse. The long-term care (LTC) home's internal investigation notes indicated that a staff member witnessed the incident on a

specified date and reported the incident after more than two weeks to the resident care coordinator (RCC).

The RCC confirmed that the staff member did not report the incident until over two weeks later and indicated that the staff member was being trained and was afraid to tell anyone.

Failing to immediately report an incident of resident abuse by staff created a risk of further abuse.

Sources: CIS report, LTC home's internal investigation notes, interview with RCC.

WRITTEN NOTIFICATION: FALLS PREVENTION AND MANAGEMENT

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (1)
Falls prevention and management
s. 54 (1) The falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative care approaches and the use of equipment, supplies, devices and assistive aids.

The licensee has failed to comply with their fall prevention and management program when a resident had an unwitnessed fall.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that the Fall Prevention and Management Program at a minimum, provide for strategies to reduce or mitigate falls and is to be complied with. Specifically, registered staff

did not comply with the policy "Post Fall Head Injury Routine Procedure", which was included in the licensee's falls prevention and management program.

Rationale and Summary

A Critical Incident System (CIS) report was submitted to the Director for an Improper/Incompetent treatment of a resident.

A review of the resident's progress notes and post-fall assessment indicated that the resident had an unwitnessed fall.

The home's Post Fall Head Injury Routine Procedure policy stated that registered staff should initiate the Head Injury Routine (HIR) with all unwitnessed falls.

A review of the CIS report and investigation notes revealed that a registered staff didn't initiate an HIR assessment until later the day the resident fell.

Resident Care Coordinator (RCC) confirmed that the registered staff didn't complete an HIR assessment as per the home's policy.

Failure to initiate an HIR assessment immediately following the unwitnessed fall may have delayed any necessary treatment if the assessment findings reveal a change in condition.

Sources: CIS report, resident's progress notes, resident's post-fall assessment, Post Fall Head Injury Routine Procedure, investigation notes, and interview with RCC.

WRITTEN NOTIFICATION: SKIN AND WOUND CARE

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NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

The licensee failed to ensure that a resident who is exhibiting altered skin integrity is reassessed at least weekly by a member of the registered nursing staff.

Rationale and Summary

A Critical Incident System (CIS) report was submitted to the Director for an alleged incident of abuse of a resident that resulted in harm to the resident.

A review of the resident's progress notes and CIS report indicated that the resident sustained a new skin injury.

A review of the resident's skin and wound assessments revealed that the skin injury was added to the medical record and assessed on a specified date, and the first reassessment was completed two weeks after the initial assessment. The wound reassessment indicated that the progress of the wound was deteriorating.

A registered staff acknowledged through their record review there was no skin and wound reassessment completed for the skin tear until two weeks later. The registered staff confirmed that the home expectation is to complete weekly skin and wound assessments at a minimum for all identified wounds.

Failing to complete weekly skin reassessments for a resident may have delayed treatment when the resident's wound deteriorated.

Sources: CIS report, the resident's progress notes, the resident's skin and wound assessments, and an interview with a registered staff.

WRITTEN NOTIFICATION: RESPONSIVE BEHAVIOURS

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee failed to ensure that when a resident was demonstrating responsive behaviours, a reassessment was completed of the Behavioural Supports Ontario-Dementia Observation System (BSO-DOS) that was recommended to monitor the effectiveness of medication changes.

Rationale and Summary

A Critical Incident System (CIS) report was submitted to the Director for an alleged incident of abuse to a resident that resulted in harm to the resident.

Resident's progress notes and analysis of the BSO-DOS on a specified date

documented to repeat the BSO-DOS on a specified date to monitor the effectiveness of an intervention for responsive behaviour.

A review of the resident's electronic and physical medical record revealed that BSO-DOS was not repeated on the specified date.

Registered staff and BSO staff confirmed that a BSO-DOS should have been completed on the specified date, but was not.

Failure to reassess the interventions of a resident's responsive behaviours reduced the home's ability to monitor the effectiveness of the interventions.

Sources: Resident's progress notes, resident's BSO-DOS, and interview with registered staff and BSO staff.

WRITTEN NOTIFICATION: ALTERCATIONS AND OTHER INTERACTIONS

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
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 licensee has failed to ensure the identified interventions to minimize the risk of altercations and potentially harmful interactions between two residents were implemented.

Rationale and Summary

A Critical Incident System (CIS) Report was submitted to the Director for an alleged incident of abuse.

Progress notes reviews indicated an incident of alleged abuse toward a resident by a coresident on a specified date. The resident sustained an injury. Following the incident, an intervention was put in place for staff to keep both residents separated. Three months later, the resident sustained an injury caused by the coresident. The resident was transferred out to the hospital due to the injury.

The Behavioural Support Ontario (BSO) /staff indicated both residents were separated and monitored after the first incident. Both residents' behaviours were assessed and interventions were put in place for staff to keep both residents apart.

The resident care coordinator (RCC) and the BSO staff both confirmed the identified interventions following the first incident were in place when the second incident occurred and that both residents should not have been in close proximity.

Failure to ensure that the identified interventions to minimize the risk of altercations and potentially harmful interactions were implemented resulted in harm to a resident.

Sources: A Critical Incident System (CIS) Report, Progress notes for both residents, Behaviour Assessment Tool (BAT) for the coresident and interviews with BSO staff and RCC.

WRITTEN NOTIFICATION: Dealing with Complaints

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (3) (a)
Dealing with complaints
s. 108 (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly;

The licensee failed to ensure that a documented record of the complaint from a resident's family member was reviewed and analyzed for trends at least quarterly.

Rationale and Summary

A critical incident report was submitted to the Director indicating that a written complaint from a family member of a resident.

The complaint alleged improper care of the resident. The long-term care home's Complaints Log was reviewed and the complaint document with the allegation of improper care of the resident was not recorded in the log.

The Executive Director confirmed that the emailed complaint received from the family member of a resident was not included in the Complaints Log, and was not reviewed and analyzed in the quarterly review and analysis for trends.

Failure to review and analyze a complaint from a family member of a resident poses a risk of missing a trend.

Sources: LTC home's Complaint Log, the complaint document, interview with the Executive Director.

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NOTICE OF RE-INSPECTION FEE Pursuant to section 348 of O. Reg. 246/22 of the Fixing Long-Term Care Act, 2021,the licensee is subject to a re-inspection fee of $500.00 to be paid within 30 days from the date of the invoice.
A re-inspection fee applies since this is, at minimum, the second follow-up inspection to determine compliance with the following Compliance Order(s) under s. 155 of the FLTCA, 2021, and/or s. 153 of the LTCHA, 2007.
Second Follow Up to an order

Licensees must not pay a Re-Inspection Fee from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services (PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the Re-Inspection Fee.