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
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775
londondistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: January 19, 2023	
Inspection Number: 2022-1144-0004	
Inspection Type: Complaint	
Licensee: Caressant Care Nursing and Retirement Homes Limited	
Long Term Care Home and City: Caressant Care Woodstock Nursing Home, Woodstock	
Lead Inspector Melanie Northey (563)	**Inspector Digital Signature** Melanie Northey Digitally signed by Melanie Northey Date: 2023.01.23 15:46:00 -05'00'
Additional Inspector(s) Ali Nasser (523)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
December 15, 19, 20, 21, 22, and 23, 2022
January 3, 4, 5, 9, 10, and 11, 2023

The following intake(s) were inspected:

- Intake: #00015102-IL-07930-LO: Complainant with concerns related to abuse by staff and multiple care concerns.

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

- Skin and Wound Prevention and Management
- Medication Management
- Skin and Wound Prevention and Management
- Reporting and Complaints
- Prevention of Abuse and Neglect
- Recreational and Social Activities

INSPECTION RESULTS

WRITTEN NOTIFICATION: Policies, etc., to be followed, and records

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 11 (1) (a)

The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, program, procedure, strategy, initiative or system, the licensee was required to ensure that the plan, policy, protocol, program, procedure, strategy, initiative or system, was in compliance with and was implemented in accordance with all applicable requirements under the Act.

Rationale and Summary
Fixing Long Term Care Act s. 26 (1) stated, "Every licensee of a long-term care home shall,
(a) ensure that there are written procedures that comply with the regulations for initiating complaints to the licensee and for how the licensee deals with complaints.
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations."

Ontario Regulation 246/22 s.108 (1) stated, "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."

The Client Services Response-Process to Address Concern/Complaint policy ID: LTC-Admin-S12-10.0 with a review date of October 28, 2022, included the following:
"Definition – Formal Complaint: A formal complaint is a verbal or written expression of dissatisfaction or concern by a resident, family member or other (persons) with the care or services provided by the home and requiring acknowledgment and action."

Procedure #1 stated, "any person receiving a written complaint (letter or e-mail format) will need to confirm with the complainant that this indeed is meant to be a formal complaint. Once confirmed as true formal complaint and not a form communication, it will be forwarded through the Critical Incident

System (CIS) and the Regional Director of Operations."

The Executive Director (ED) stated the home's policy was not in compliance with the act or regulation and that they were going to communicate with the corporate office to review and change the policy accordingly.

Sources: the Client Services Response-Process to Address Concern/Complaint policy and ED interview. [523]

WRITTEN NOTIFICATION: Duty to Protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that the resident was not neglected by the licensee or staff.

Rationale and Summary
Ontario Regulation 246/22, s. 7 stated, "For the purposes of the Act and this Regulation, "neglect" means 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."

The Ministry of Long-Term Care received a complaint, and the complainant said the home neglected a resident that resulted in harm. Multiple progress notes on different dates documented new areas of altered skin integrity noted. At times the cause was unknown and another time the resident sustained an injury during personal care.

A Registered Nurse (RN) thought the resident's altered skin integrity was a result of improper care. The RN reviewed the resident's plan of care and stated the plan of care was not updated and did not include specific interventions or direction to staff related to the resident's specific care to prevent injury.

The Executive Director stated no action was taken to investigate the incidents of altered skin integrity and injury during care, staff were not interviewed, and interventions were not reviewed as part of the resident's plan of care required for health, safety or well-being.

The resident had multiple areas of altered skin integrity. Nursing staff verified the altered skin integrity was caused during personal care and there was no investigation and no follow up with specific

interventions to prevent reoccurrence putting the resident at continued risk of harm. There was a failure to provide the resident with the treatment, care, and assistance required for their safe care and the continued pattern of inaction after each new injury jeopardized the health, safety, or well-being of the resident.

Sources: clinical record review for the resident, interview with the resident's family and staff interviews. [523]

WRITTEN NOTIFICATION: Reporting Certain Matters to the Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident has occurred or may occur immediately reported the suspicion and the information upon which it was based to the Director.

Rationale and Summary
Th Skin and Wound Lead, Registered Nurse (RN) said they provided skin and wound care and completed skin assessments for the resident and said the areas of altered skin integrity were a result of improper care. The RN said they informed the previous Director of Care (DOC) about the areas of altered skin integrity.

The RN said they were informed of the injury during the personal care of resident and the injury was a direct result of the assistive devices used during care. The RN said this incident was a result of improper care and said the Assistant DOC was aware of the incident.

The Executive Director (ED) said the incidents of improper care were not reported to the Director.

Sources: clinical record review for the resident and staff interviews.
[523]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (1) 1.

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 was investigated and resolved where possible, and a response that complied with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleged harm or risk of harm including, but not limited to, physical harm, to one or more residents, the investigation shall be commenced immediately.

Rationale and Summary
The Ministry of Long-Term Care received a complaint, and the complainant said they shared with the home on multiple occasions care concerns related to the resident, but the home did not investigate those concerns.

A progress note for the resident was completed by a Registered Practical Nurse (RPN) and documented that the resident's family called with several complaints related to skin injuries. The RPN offered to transfer the call to management, but family stated they would speak with management on Monday regarding all the above.

The Executive Director (ED) said there was no documented record that the resident care complaint was investigated.

2) The Registered Nurse (RN) stated they had a conversation with the resident's family who expressed care concerns related to areas of altered skin integrity on multiple areas of the resident's body. The RN was told by the family that this kept happening and the staff did not know why it was happening and were not doing anything about it. The RN said that they did not investigate the care concerns expressed by the resident's family.

A lack of investigation placed the resident at continued potential risk of injury and altered skin integrity.

Sources: review of the "CLIENT SERVICE RESPONSE (Concern or Complaint) - FORMs" and staff interviews.
[523]

WRITTEN NOTIFICATION: Reporting and Complaints

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2) (a)

The licensee has failed to ensure that a documented record was kept in the home that included the

nature of each verbal or written complaint.

Rationale and Summary
The Ministry of Long-Term Care received a complaint, and the complainant said they shared with the home on multiple occasions care concerns related to the resident, but the home did not investigate those concerns.

The Executive Director (ED) and Assistant Director of Care (ADOC) stated the home's process was for any person receiving a complaint to document the complaint on a Client Service Response Form.

A progress note for the resident was completed by a Registered Practical Nurse (RPN) and documented that the resident's family called with several complaints related to skin injuries. The RPN offered to transfer the call to management, but family stated they would speak with management on Monday regarding all the above.

The ADOC said they received several complaints from resident's family and both the ED and ADOC verified there was no documented record of the complaints received related to the resident.

Sources: review of the "CLIENT SERVICE RESPONSE (Concern or Complaint) - FORMs" and staff interviews.
[523]