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

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Original Public Report

Report Issue Date: January 19, 2023	
Inspection Number: 2022-1144-0003	
Inspection Type: Complaint Follow up Critical Incident System	
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 15:50:28 -05'00'
Additional Inspector(s) Ali Nasser (523)	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
December 13, 14, 15, 20, 21, 22 and 23, 2022
January 3, 4, 5, 6, 9, 10 and 11, 2023

The following intake(s) were inspected:
Follow Up:

- Intake: #00015445 from Inspection #2022_1144_0001, Compliance Order (CO) #001, Director Referral (DR) #001, FLTCA, 2021 [s. 5] Safe & Secure, with a Compliance Due Date (CDD) November 28, 2022
- Intake: #00015447 from Inspection #2022_1144_0002, CO #001, FLTCA, 2021 [s. 5] Safe & Secure, with a CDD November 28, 2022
- Intake: #00015446 from Inspection #2022_1144_0002, CO #002, FLTCA, 2021, [s. 27 (1)(a)(i)] License Must Investigate, Respond and Act, with a CDD October 24, 2022
- Intake: #00015450 from Inspection #2022_1144_0002, CO #003, O. Reg. 246/22 [s. 96 (2)(a)] Maintenance Services (mechanical lifts), with an amended CDD December 12, 2022
- Intake: #00015448 from Inspection #2022_1144_0002, CO #004, O. Reg. 246/22 [s. 55 (2)(b)(ii)] Skin & Wound, with a CDD October 24, 2022.
- Intake: #00015449 from Inspection #2022_1144_0002, CO #005, O. Reg. 246/22 [s. 95 (1)(b)] Laundry Services, with an amended CDD December 12, 2022

Critical Incident (CI):

- Intake: #00013495/CI: 2636-000042-22 related to the Fall Prevention Program

Complaint:

- Intake: #00008770/IL-05869-LO related to nursing and personal support services

The following intake(s) were completed in this inspection related to the Fall Prevention Program:

- Intake: #00001132/CI: 2636-000008-22
- Intake: #00006189/CI: 2636-000006-22
- Intake: #00007338/CI: 2636-000030-22
- Intake: #00015192/CI: 2636-000047-22
- Intake: #00016630/CI: 2636-000049-22

Previously Issued Compliance Order(s)

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

Order #001 and Director Referral #001 from Inspection #2022-1144-0001 related to FLTCA, 2021 [s. 5] inspected by Ali Nasser (523)

Order #001 from Inspection #2022-1144-0002 related to FLTCA, 2021 [s. 5] inspected by Ali Nasser (523)

Order #002 from Inspection #2022-1144-0002 related to FLTCA, 2021, [s. 27 (1)(a)(i)] inspected by Melanie Northey (563)

Order #003 from Inspection #2022-1144-0002 related to O. Reg. 246/22, s. 96 (2) (a) inspected by Melanie Northey (563)

Order #004 from Inspection #2022-1144-0002 related to O. Reg. 246/22, s. 55 (2) (b) (ii) inspected by Melanie Northey (563)

Order #005 from Inspection #2022-1144-0002 related to O. Reg. 246/22, s. 95 (1) (b) inspected by Melanie Northey (563)

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

- Housekeeping, Laundry and Maintenance Services
- Skin and Wound Prevention and Management
- Prevention of Abuse and Neglect
- Resident Care and Support Services
- Falls Prevention and Management
- Safe and Secure Home
- Infection Prevention and Control
- Reporting and Complaints

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of Care

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 the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

Rationale and Summary
The resident stated Personal Support Workers (PSWs) provided personal care that caused an injury. There was no intervention as part of the plan of care for the resident instructing staff to prevent further potential injuries to the resident. The Executive Director stated the plan of care was not revised to indicate specific interventions to prevent potential injuries during personal care and verified an intervention should have been added to the resident's plan of care to direct staff.

Sources: clinical record review for the resident, and resident and staff interviews.
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WRITTEN NOTIFICATION: Reports re Critical Incidents

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 115 (3) 4.

The licensee failed to ensure that the Director was informed of an incident that caused an injury to a

resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition no later than one business day after the occurrence of the incident.

Ontario Regulation 246/22, s. 115. (8) states, "significant change" means a major change in the resident's health condition that,
(a) will not resolve itself without further intervention,
(b) impacts on more than one aspect of the resident's health condition, and
(c) requires an assessment by the interdisciplinary team or a revision to the resident's plan of care.

Rationale and Summary
During the follow-up inspection, a resident was interviewed and stated Personal Support Workers (PSWs) provided personal care that caused an injury.

A progress note for the resident was completed by a Registered Practical Nurse (RPN) and documented the resident reported to the RPN that the PSWs provided personal care that caused an injury. The physician was notified, and an order was received to transfer the resident for acute care. The RPN documented that the Director of Care (DOC) was notified.

The Executive Director (ED) stated this was considered an incident that caused an injury to the resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition. The ED verified the home did not complete a Critical Incident System Report to ensure that the Director was informed of an incident that caused an injury to the resident for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition no later than one business day after the occurrence.

Sources: clinical record review for the resident, and the resident and staff interviews.
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WRITTEN NOTIFICATION: Reporting and Complaints

NC #003 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
During the follow-up inspection, a resident was interviewed and stated Personal Support Workers (PSWs) provided personal care that caused an injury.

A progress note for the resident was completed by a Registered Practical Nurse (RPN) and documented the resident reported to the RPN that the PSWs provided personal care that caused an injury. The physician was notified, and an order was received to transfer the resident for acute care. The RPN documented that the Director of Care (DOC) was notified.

The Executive Director (ED) stated there was no documented record of a "CLIENT SERVICE RESPONSE (Concern or Complaint) – FORM" related to the resident's reported injury during personal care. The ED verified the incident was a verbal complaint made to a staff member by the resident concerning their care. The ED stated an investigation should have been completed to determine cause of the injury and staff interviewed.

Sources: review of the "CLIENT SERVICE RESPONSE (Concern or Complaint) - FORMs", clinical record for the resident, and the resident and staff interviews.
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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 (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
During the follow-up inspection, a resident was interviewed and stated Personal Support Workers (PSWs) provided personal care that caused an injury.

A progress note for the resident was completed by a Registered Practical Nurse (RPN) and documented the resident reported to the RPN that the PSWs provided personal care that caused an injury. The physician was notified, and an order was received to transfer the resident for acute care. The RPN documented that the Director of Care (DOC) was notified.

The Executive Director (ED) stated there was no documented record of a “CLIENT SERVICE RESPONSE (Concern or Complaint) – FORM” related to the resident’s reported injury during personal care. The ED verified the incident was a verbal complaint made to a staff member by the resident concerning their care and there was no documented record kept in the home.

Sources: review of the “CLIENT SERVICE RESPONSE (Concern or Complaint) - FORMs", clinical record for the resident, and the resident and staff interview
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