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

Amended Public Report Cover Sheet (A1)

Amended Report Issue Date: January 22, 2024
Original Report Issue Date: December 29, 2023
Inspection Number: 2023-1311-0005 (A1)
Inspection Type: Complaint Critical Incident
Licensee: Caressant-Care Nursing and Retirement Homes Limited
Long Term Care Home and City: Caressant Care Courtland, Courtland

Amended By Tatiana McNeill (733564)	**Inspector who Amended Digital Signature** Tatiana McNeill Digitally signed by Tatiana McNeill Date: 2024.01.23 09:38:24 -05'00'

AMENDED INSPECTION SUMMARY

This report has been amended to reflect the change in Compliance Order #001 due date from February 5, 2024 to February 29, 2024, and the change in Compliance Order #002 due date from March 25, 2024 to May 10, 2024.

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Amended Public Report (A1)

Amended Report Issue Date: January 19, 2024	
Original Report Issue Date: December 29, 2023	
Inspection Number: 2023-1311-0005 (A1)	
Inspection Type: Complaint Critical Incident	
Licensee: Caressant-Care Nursing and Retirement Homes Limited	
Long Term Care Home and City: Caressant Care Courtland, Courtland	
Lead Inspector Tatiana McNeill (733564)	**Additional Inspector(s)** Christie Birch (740898)
Amended By Tatiana McNeill (733564)	**Inspector who Amended Digital Signature**

AMENDED INSPECTION SUMMARY

This report has been amended to reflect the change in Compliance Order #001 due date from February 5, 2024 to February 29, 2024, and the change in Compliance Order #002 due date from March 25, 2024 to May 10, 2024.

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: December 4, 5, 6, 7, 8, and 11, 2023

The following intakes were inspected:

- Intake: #00096422 – [CI: 2826-000021-23] related to Falls Prevention and Management.
- Intake: #00098863 – Complainant regarding multiple concerns related to care and services.
- Intake: #00098915 – [CI: 2826-000024-23] related to Falls Prevention and Management.
- Intake: #00100132 – [CI 2826-000026-23] related to Falls Prevention and Management.

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

Resident Care and Support Services
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Staffing, Training and Care Standards
Falls Prevention and Management

AMENDED 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 (1) (c)

Plan of care

s. 6 (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,

(c) clear directions to staff and others who provide direct care to the resident.

The licensee has failed to ensure that the written plan of care for a resident set out clear direction to staff and others who provided care to the resident.

Rationale and Summary
A Critical Incident (CI) was submitted to the Director related to an incident where a resident fell.

A record review of the care plan noted an intervention of "PASD is applied as per manufacturer's instructions".

In an interview with two Personal Support Workers (PSW) and a Registered Practical Nurse (RPN), they confirmed they were not aware of what the manufacturer's instructions for the resident's equipment were.

In an interview with the Director of Care (DOC) , they confirmed they were not aware of what the manufacturer's instructions were for the resident's equipment and that the care plan did not provide clear direction to staff.

In an interview with the Occupational Therapist (OT) and the Physiotherapist (PT), both were not able to confirm the safe use of the equipment for the resident.

There was risk to the resident related to the unclear directions to staff on the use of the resident's equipment.

Sources:: Review of clinical records for the resident, interview with staff, Director of Care, Occupational Therapist, and Physiotherapist.
[740898]

WRITTEN NOTIFICATION: Air Temperature

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 24 (1)
Air temperature
s. 24 (1) Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

The licensee has failed to ensure that the home was maintained at a minimum temperature of 22 degrees Celsius.

Rationale and Summary
inspector #733564 and Inspector #740898 noted the air temperature in an area of the home to be cold, and the thermostat reading to be 19.98 degrees Celsius.

Environmental Services Supervisor stated that the temperature taken was below the legislation requirement of a minimum of 22 degrees Celsius.

There was risk to the residents related to the lower temperatures in resident's home areas.

Sources: observations in the home, and interview with Environmental Services Supervisor.
[733564]

WRITTEN NOTIFICATION: General requirements

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (1) 4.
General requirements
s. 34 (1) Every licensee of a long-term care home shall ensure that the following is

complied with in respect of each of the organized programs required under sections 11 to 20 of the Act and each of the interdisciplinary programs required under section 53 of this Regulation:
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

The licensee failed to ensure that the written record relating to the evaluation of the Falls Prevention and Management Program included a summary of the changes made and the date that those changes were implemented.

Rationale and Summary
A record review of the home's evaluation of the Falls Program, dated May 31, 2023, did not indicate a summary of changes made and any dates that those changes were made.

In an interview with the Director of Care (DOC), they confirmed the evaluation did not indicate a summary of changes made and dates those changes were made.

Sources: Review of the home's evaluation of the Falls Program, interview with the DOC.
[740898]

WRITTEN NOTIFICATION: Falls Prevention and Management

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 54 (2)
Falls prevention and management
s. 54 (2) Every licensee of a long-term care home shall ensure that when a resident

has fallen, the resident is assessed and that a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 246/22, s. 54 (2); O. Reg. 66/23, s. 11.
1. The licensee failed to ensure that when a resident fell, the resident was assessed and that a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Rationale and Summary
The resident had an unwitnessed fall. There was no post fall assessment completed for the resident.

Registered Nurse (RN) and the Director of Care (DOC), both confirmed that a post falls assessment should have been completed.

There was risk to the resident as there was no documentation related to the resident's fall or contributing factors to prevent further falls.

Sources: Review of Resident's clinical records, Point Click Care (PCC) file, review of the home's Fall Management Program- Post Fall Management Procedure LTC-NURSS10-40.0 and interviews with staff.

2. The licensee failed to ensure that when a resident fell, the resident was assessed and that a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Rationale and Summary
The resident had an unwitnessed fall. There was no post fall assessment completed for the resident.

Director of Care (DOC), confirmed that a post falls assessment should have been completed.

There was risk to the resident as there was no documentation related to the resident's fall or contributing factors to prevent further falls.

Sources: Review of resident's clinical records, Point Click Care (PCC) file, review of the home's Fall Management Program- Post Fall Management Procedure LTC-NURSS10-40.0 and interviews with staff.
[740898]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (i)
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,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

The licensee failed to ensure that a resident received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, when they exhibited a new skin impairment.

Rationale and Summary
In an interview with a Registered Nurse (RN), they stated that the resident had a new

skin impairment. The RN stated that they provided skin treatment and confirmed that they did not complete a new skin and wound assessment in Point Click Care (PCC) or any other documentation as they should have.

A record review of the Skin and Wound Program- Skin Assessment (Head to Toe) Procedure, LTC-NURSS4-70.0, effective date: July 26, 2022, supersedes: November 1, 2019, reviewed date: July 26, 2022 noted the following:
"A Skin Assessment (previous head to toe assessment) will be completed by the Nurse for all Residents at risk of altered skin integrity under the following circumstances:
• Change in health status that affects skin integrity (e.g., after a fall with skin damage-skin tear)"
In a review of the resident's progress notes, a skin and wound assessment was not completed on the day the skin impairment was discovered.

Sources: Review of Skin and Wound Program- Skin Assessment (Head to Toe) Procedure, Policy -LTC-NURSS4-70.0, review of resident's clinical records, interview with staff.
[740898]

WRITTEN NOTIFICATION: Dining and Snack Service

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (2) (b)
Dining and snack service
s. 79 (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

A complaint was reported to the Ministry of Long-Term Care (MLTC) regarding care

concerns for a resident.

Rationale and Summary
Meal observations completed by Inspector #733564 and #740898 noted residents who required assistance with feeding were served their meals prior to staff members being available to provide assistance with feeding. During meal service, the resident was observed to have a meal served to them before someone was available to provide assistance with eating. Observations of meal service noted that staff members provided assistance with eating to the resident after they completed other meal services tasks.

Review of the resident's care plan indicated they required assistance with eating. Nutrition Manager stated that the home's expectation was that staff members were to serve the food when assistance required by the resident was available.

There was risk that the residents' meals could be cold and unpleasant when their meals had been served, when they were waiting for someone to come and provide the assistance they required.

Sources: review of resident's clinical records, observations of meal service, and interview with Nutrition Manager.
[733564]

COMPLIANCE ORDER CO #001 Compliance with manufacturers' instructions

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 26
Compliance with manufacturers' instructions
s. 26. Every licensee of a long-term care home shall ensure that staff use all

equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee must ensure that,
A) All wheelchairs are used according to the manufacturer's instructions at all times.
B) The manufacturer's instructions are available in the home for all equipment.
C) All nursing staff are educated on the appropriate use of each equipment in the home, according to the manufacturer's instructions.
D) The education provided is documented, including the date and names of staff members involved; education records are to be maintained and made available for inspector review.
E) Weekly audits are performed to ensure the manufacturer's instructions are being followed for the use of equipment in the home for a period of one month after the education is completed, and until no further concerns arise.
F) The audits are documented, indicating date and specific equipment, if any concerns were identified and if any follow up action was required.

Grounds
The licensee has failed to ensure that staff used a resident's equipment in accordance with the manufacturer's instructions.

Rationale and Summary
A Critical Incident (CI) was submitted to the Director related to an incident where resident's equipment was not used according to the manufacturer's instructions.

A record review of the home's Personal Assistive Safety Devices (PASDs) P & P -

LTC-NURSS7-50.0 effective date: May 3, 2023, supercedes: November 1, 2019, reviewed date: May 3, 2023, stated "All PASDs shall be well maintained and applied as per manufacturer's instructions".

In an interview with a Personal Support Worker (PSW), they stated that they had used the resident's equipment. The PSW stated that they were unaware of specific manufacturer's instructions for safe use of the equipment.

In a review of the progress notes for the resident, it was noted that the resident had an incident where there was risk of injury related to their equipment not being used as per manufacturers instructions.

In an interview with Physiotherapist Assistant (PTA) and the Director of Care (DOC) they confirmed they were not aware of what the manufacturer's instructions for the resident's equipment were and the home did not have those manufacturer's instructions available for this resident's equipment.

Sources: Interviews with staff, Occupational Therapist, Physiotherapist, record review of resident's paper file and Point Click Care (PCC) notes, review of the home's Personal Assistive Safety Devices (PASDs) P & P - LTC-NURSS7-50.0.
[740898]

This order must be complied with by February 29, 2024

COMPLIANCE ORDER CO #002 Availability of supplies

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 48
Availability of supplies
s. 48. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care

needs of residents.

The Inspector is ordering the licensee to prepare, submit and implement a plan to ensure compliance with [FLTCA, 2021, s. 155 (1) (b)]:

The licensee shall prepare, submit and implement a plan to hire a contractor to ensure the home has the required facilities and equipment to be able to provide tub baths for any resident whose preference is a tub bath.
The plan shall include but is not limited to:
1. A description of the steps that will be taken to ensure the home has the required facilities and equipment to be able to provide tub baths for any resident who requests them.
2.The person(s) responsible for each step of the plan, the anticipated completion date for each step, and the final date of completion.
3.Include a description of the steps that would be taken to ensure a tub bath is provided to any residents whose preference is a tub bath.

Please submit the written plan for achieving compliance for inspection #2023-1311-0005 to Tatiana McNeill (733564), LTC Homes Inspector, MLTC, by email to londondistrict.mltc@ontario.ca by January 15, 2024.
Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds
The licensee has failed to ensure that bathing equipment was readily available at the home to meet the personal care requirements for residents.

Review of Point Click Care (PCC) care plan report noted several residents preferred to have a bath, but the home could not accommodate due to the physical structure of the tub room.

Interview with family member for a resident noted resident's preferred method of bathing was a tub bath. Family member for the resident stated that they have had continued issues with baths and have requested the home to provide a bath to the resident but did not know if a bath was provided at this time.

Environmental Services Manager noted that the entrance to the tub rooms was too narrow and could not accommodate certain mobility aides. Environmental Services Manager noted that the licensee of the home was looking into remodeling of the home's tub bath rooms to ensure that all residents who preferred a tub bath could utilize the tub bath rooms.

Director of Care stated that the residents should have received their preferred method of bathing.

The home not having the facilities and equipment required to be able to provide tub baths for residents whose preference were tub baths potentially affected resident's quality of life when their preferences with regards to bathing were not considered.

Sources: Review of Point Click Care (PCC) care plan report for several residents, interview with POA for a resident, and Environmental Services Manager.
[733564]

This order must be complied with by May 10, 2024

COMPLIANCE ORDER CO #003 Required programs

NC #010 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 53 (1) 1.
Required programs
s. 53 (1) Every licensee of a long-term care home shall ensure that the following

interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
Specifically, the licensee must ensure:

A) Two specific residents have a head injury routine (HIR) completed as required when a new fall occurs, according to home's policy.
B) Two specific residents have documentation completed in the progress notes related to falls as per policy.
C) Staff are notified at shift report when two specific residents have a fall and that there is documentation of this communication.
D) Retrain all registered nursing staff of the home's post falls management policy. A record must be kept of the training, including the contents of the training, the dates of the training, the name of the trainer and the staff members who completed the training.
E) Perform weekly audits for all falls of all residents for one month, including post falls documentation such as HIR, Post falls assessment, documentation in progress notes and communication of the fall at shift report. A record of this audit is to be kept with the details of the items audited, dates of the audits, person who performed the audit, results of the audit and any actions taken as a result of the audit.

Grounds
1) The licensee has failed to comply with the home's falls prevention and management policy when a resident had a fall.

Rationale and Summary

In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee was required to ensure that written policies and protocols were developed for the falls prevention and management program and ensure they were complied with.
Specifically, staff did not comply with the licensee's Fall Management Program- Post Fall Management Procedure, related to Head Injury Routine (HIR), notifying staff, and follow up documentation post fall.

The home's Fall Management Program- Post Fall Management Procedure LTC-NURSS10-40.0 Effective date: September 18, 2023, Supercedes: March 1, 2021, reviewed date: September 18, 2023, stated after a resident fell they required a post fall assessment, a Head Injury Routine (HIR), and the fall was communicated to staff.

The home's Post Fall Head Injury Routine Procedure LTC-NURSS10-50, Effective Date April 13, 2023, Supercedes: March 21, 2023, Reviewed date October 30, 2023, stated if a resident hits their head or is suspected of hitting their head (e.g. unwitnessed fall), staff were to complete a Clinical Monitoring Record, which included neurovital signs.
The resident had an unwitnessed fall.

In an interview, Registered Nurse (RN) confirmed they had not completed documentation post fall. They also confirmed they had not notified the next shift of the resident's fall.

In an interview with the Director of Care (DOC) they confirmed that staff were not notified of the fall at shift report and should have been. The DOC also confirmed that post falls documentation should have been completed as part of the post fall procedure for unwitnessed falls and had not been completed at the time of the fall.

There was risk to the resident of missing post falls injuries.

Sources: A Critical Incident System (CIS) report, the resident's clinical records, the home's Fall Management Program- Post Fall Management Procedure LTC-NURSS10-40.0, the home's Post Fall Head Injury Routine Procedure LTC-NURSS10-50 and interviews with the DOC and other staff.
[740898]

2) The licensee has failed to comply with the home's falls prevention and management policy when a resident had an unwitnessed fall.

Rationale and Summary
In accordance with O. Reg 246/22 s. 11 (1) (b) the licensee was required to ensure that written policies and protocols were developed for the falls prevention and management program and ensure they were complied with.

Specifically, staff did not comply with the licensee's Fall Management Program-Post Fall Management Procedure LTC-NURSS10-40.0, related to Head Injury Routine (HIR), notifying staff, and follow up documentation post fall.

A resident had an unwitnessed fall.

In a record review of the resident's clinical records, there was no post fall assessment, progress notes or a Clinical Monitoring Record, including a HIR documented.

In an interview, the Director of Care (DOC) confirmed the registered staff had not completed documentation post fall, including progress notes or a Clinical Monitoring Record for HIR and should have. They also confirmed they had not

notified the next shift of the resident's fall and should have.

There was risk to the resident of missing post falls injuries.

Sources: A Critical Incident System (CIS) report, the resident's clinical records, the home's Fall Management Program- Post Fall Management Procedure LTC-NURSS10-40.0, the home's Post Fall Head Injury Routine Procedure LTC-NURSS10-50 and interviews with the DOC and other staff.
[740898]

This order must be complied with by February 5, 2024

COMPLIANCE ORDER CO #004 Bathing

NC #011 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 37 (1)
Bathing
s. 37 (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

1. Specifically, the licensee must ensure several residents are bathed at a minimum twice per week by the method of their choice.

Grounds

The licensee has failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Review of Activities of Daily Living (ADL) report noted that several residents were not bathed at a minimum twice a week by the method of their choice.

Director of Care (DOC) and Executive Director (ED) acknowledged that the residents should have been bathed at a minimum twice a week by the method of their choice. DOC and ED also acknowledged that tub baths were not available and provided to all residents with this preference due to the restrictions of the physical structure of the tub rooms.

There was a risk to residents when they were not bathed at a minimum twice a week by the method of their choice.

Sources: Review of Activities of Daily Living report, interviews with Director of Care and Executive Director.

[733564]

This order must be complied with by March 25, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE

The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.