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
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Original Public Report

Report Issue Date: July 9, 2024

Inspection Number: 2024-1311-0001

Inspection Type:
Complaint
Critical Incident
Follow-up

Licensee: Caressant-Care Nursing and Retirement Homes Limited

Long Term Care Home and City: Caressant Care Courtland, Courtland

Lead Inspector	**Inspector Digital Signature**
Tatiana McNeill (733564)	Tatiana McNeill Digitally signed by Tatiana McNeill Date: 2024.07.10 07:43:47 -04'00'

Additional Inspector(s)
Christie Birch (740898)
Ina Reynolds (524)
Joy Kacsandi (000821)
Mark Smith (000815)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 18, 20, 21, and 25, 2024
The inspection occurred offsite on the following date(s): June 19, and 26, 2024

The following intake(s) were inspected:

- Intake: #00104760 – CIS # 2826-000033-23 -related to Falls Prevention and Management

- Intake: #00107565 – CIS # 2826-000001-24 – related to Prevention of Abuse and Neglect
- Intake: #00110013 – Follow-Up Intake for Compliance Order #001 from Inspection #2023-1311-0005 related to O. Reg. 246/22, s. 26 with a Compliance Due Date of February 29, 2024
- Intake: #00110014 – Follow-Up Intake for Compliance Order #003 from Inspection #2023-1311-0005 related to O. Reg. 246/22, s. 53 (1) 1 with a Compliance Due Date of February 5, 2024
- Intake: #00111419 – CIS # 2826-000010-24- related to an outbreak
- Intake: #00112414 - Follow Up Intake for Compliance Order #004 from Inspection #2023-1311-0005 related to O. Reg. 246/22, s. 37 (1) with a Compliance Due Date of May 10, 2024
- Intake: #00113098 – CIS # 2826-000015-24 -related to Prevention of Abuse and Neglect
- Intake: #00114442 – CIS# 2826-000017-24 -related to Prevention of Abuse and Neglect
- Intake: #00114657 – complaint related to care concerns for a resident
- Intake: #00115907 – CIS # 2826-000018-24 -related to Prevention of Abuse and Neglect
- Intake: #00117182 – Follow-up Intake related to Compliance Order #002 from Inspection #2023-1311-0005 related to O. Reg. 246/22, s. 48 with a Compliance Due Date of May 10, 2024

Program Specialist Christy Legouffe was on site on June 18, 20, and 21, 2024.

Previously Issued Compliance Order(s)

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

Order #001 from Inspection #2023-1311-0005 related to O. Reg. 246/22, s. 26 inspected by Christie Birch (740898)

Order #003 from Inspection #2023-1311-0005 related to O. Reg. 246/22, s. 53 (1) 1. inspected by Christie Birch (740898)

Order #004 from Inspection #2023-1311-0005 related to O. Reg. 246/22, s. 37 (1) inspected by Tatiana McNeill (733564)

Order #002 from Inspection #2023-1311-0005 related to O. Reg. 246/22, s. 48 inspected by Tatiana McNeill (733564)

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Residents' Rights

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 16.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

16. Every resident has the right to proper accommodation, nutrition, care and services consistent with their needs.

The licensee has failed to ensure that a resident was cared for in a manner consistent with their needs.

Rationale and Summary

A critical Incident System (CIS) report submitted by the home identified that a resident reported to nursing staff that they rang their call bell for assistance and had to wait until they receive the required help.

Review of the Minimum Data Set (MDS) Quarterly review assessment, the plan of care and interview with a Personal Support Worker (PSW) indicated the resident received assistance for all cares.

The home launched an internal investigation into the incident and concluded that the PSW had responded to the resident's request for assistance but had not provided the resident with the required care consistent with their needs.

Executive Director (ED) stated that the PSW did not provide the care the resident had requested. There was an increased risk of skin impairment for the resident when

their care requirements were not promptly met.

Sources: CIS report, the home's investigation notes, resident's clinical records, and interviews with ED and PSW.[524]

WRITTEN NOTIFICATION: Policy to Promote Zero Tolerance of Abuse and Neglect not complied with.

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 25 (1)
Policy to promote zero tolerance
s. 25 (1) Without in any way restricting the generality of the duty provided for in section 24, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with.

The licensee has failed to ensure that the home's policy to promote zero tolerance of abuse and neglect of residents was complied with for a resident.

Rationale and Summary:
A Critical Incident System (CIS) report to the Director documented an allegation of abuse by a staff member towards a resident. The CIS report stated that the Executive Director was not made aware of the allegations until a later time. The licensee's policies and procedure titled Zero Tolerance of Abuse and Neglect (Effective April 2024), stated that all staff must immediately report to the registered staff suspected or witnessed abuse of a resident by anyone. If the situation happened after regular business hours the staff were to immediately inform the Registered Nurse (RN) in charge and the RN in charge would notify the manager on call for direction. The policy also stated that corrective action would be taken

against anyone who failed to immediately report suspected abuse once it becomes known that they were withholding the information.

The resident stated that they had reported the allegation immediately to Personal Support Workers in the home.

A Personal Support Worker (PSW) stated that they did not immediately report the concerns brought to them by a resident related to the allegation of abuse to the RN. They also stated that they did not receive corrective action by the home related to late reporting.

The CIS report indicated that a Registered Nurse (RN) was made aware of the allegation of abuse the night before they reported it to the Executive Director (ED). During an interview, the RN stated that they did not receive corrective action by the home related to late reporting of the allegations. ED acknowledged that the expectation was that staff would immediately report allegations of abuse of a resident but did not.

There was a risk to the resident when allegations of abuse were not reported immediately by staff.

Sources: CIS report, the home's investigation notes, Caressant Care Courtland policies to promote Zero Tolerance of Abuse and Neglect and Critical inicdent Reporting procedures and staff interviews. [000821]

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #003 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 has failed to ensure an allegation of abuse to a resident was immediately reported to the Director.

Rationale and Summary
A) A Critical Incident System (CIS) report submitted by the home identified that a resident reported an allegation of abuse by a staff member towards a resident to multiple Personal Support Workers (PSW). The homes investigation determined that the Executive Director (ED) was not made aware of the allegations until a later date. In an interview ED acknowledged that the allegation should have been reported immediately but was not.

Sources: CIS report, the home's investigation notes, and interviews with ED, and other staff. [000821]

B) The licensee has failed to ensure an allegation of abuse by a staff member towards a resident was immediately reported to the Director.

Rationale and Summary
A Critical Incident System (CIS) report to the Director documented an allegation of physical abuse by a staff member towards a resident. The incident was not reported to the Director until a later date.
Review of the home's investigation notes documented a staff

counselling/education letter to a Registered Nurse (RN) regarding mandatory reporting. The letter clarified the expectation was that for any allegation of abuse they were required to notify the Manager on call and start a CI based on mandatory reporting requirements.

Executive Director (ED) acknowledged that the critical incident was not immediately reported to the Director and should have been. There was minimal risk associated with the home failing to immediately report to the Director.

Sources: CIS report, the home's investigation notes, resident's clinical records, and interview with ED. [524]

WRITTEN NOTIFICATION: Skin and Wound Care

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 55 (2) (a) (ii)
Skin and wound care
s. 55 (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(ii) upon any return of the resident from hospital, and

The licensee failed to ensure that a resident received a skin assessment when they returned from receiving medical care.

Rationale and Summary:
A Critical Incident System (CIS) report was received by the Director as a result of a fall sustained by a resident. Record review of Point Click Care (PCC) progress notes

for the resident indicated that they had returned from receiving medical care and sustained injuries. Record review of the home's "Prevention of Skin Breakdown Procedure (LTC-NURS-S4-80.0; last reviewed April 12, 2024)" stated that "All Residents will have a skin assessment (head to toe) completed: Within 24 hours of move in, Upon return from the hospital, Upon return from a LOA (Leave of Absence) greater than 24hours, Whenever there is a change in health status that affects skin integrity."

In interviews with a Registered Practical Nurse (RPN) and Director of Care (DOC) they both stated that an assessment was not completed.

Failure to complete an assessment for the resident, on return from receiving medical care, placed the resident's skin integrity at risk.

Sources: Review of clinical records for resident, review of "Prevention of Skin Breakdown Procedure (LTC-NURS-S4-80.0; last reviewed April 12, 2024) policy, interviews with RPN and DOC. [000815]

WRITTEN NOTIFICATION: Notification re Incidents

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 104 (1) (a)
Notification re incidents
s. 104 (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and

The licensee has failed to ensure that a resident's substitute decision-maker (SDM) was notified immediately upon becoming aware of any alleged, suspected or witnessed incident of abuse of the resident that resulted in physical injury.

Rationale and Summary

A complaint submitted to the Ministry of Long-Term Care (MLTC) alleged an incident of abuse. The complainant stated a resident reported to staff that the person that provided care to them had caused them an injury. The notification of the abuse to the Substitute Decision Maker (SDM) occurred later after the incident happened.

Review of a critical incident submitted to the Director, the home's investigation notes, and progress notes alleged an incident of staff to resident abuse.

Executive Director (ED) acknowledged the resident's SDM was notified of the incident at a later date after the incident occurred. There was minimal risk associated with the home failing to immediately notify the SDM.

Sources: CIS report, resident's clinical records, the home's investigation notes and interview with ED. [524]