Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 24, 2017	2016_262523_0040	019479-16, 020115-16, 031240-16	Complaint

Licensee/Titulaire de permis

CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE WOODSTOCK ON N4S 3V9

Long-Term Care Home/Foyer de soins de longue durée

CARESSANT CARE FERGUS NURSING HOME
450 QUEEN STREET EAST FERGUS ON N1M 2Y7

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

ALI NASSER (523)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 26, 27, 28, 31, November 1, 2, 3, 4, 7, 8 and 9 2016.

This inspection was completed for the following:
Log # 019479-16, CIS # 2603-000014-16, related to resident fall.
Log # 020115-16, CIS # 2603-000017-16, related to a complaint related to care concerns.
Log # 031240-16, complaint related to alleged resident to resident abuse and care concerns.

The following inspections were completed concurrently during this inspection:

Log # 024797-16, CIS # 2603-000030-16, related to alleged resident to resident abuse.
Log # 015973-16, CIS # 2603-000004-16, related to a resident fall.
Log # 015983-16, CIS # 2603-000011-16, related to a resident fall.
Log # 030691-16, CIS # 2603-000037-16, related to a resident fall.
Log # 029715-16, CIS # 2603-000034-16, related to a resident fall.
Log # 024046-16, CIS # 2603-000028-16, related to alleged resident to resident abuse.
Log # 027922-16, Complaint # IL-46787-LO related to wound care.
Log # 020794-16, Complaint # IL-45667-LO related to resident care concerns.
Log # 020460-16, Complaint # IL-45482-LO, related to resident's rights.
Log # 020595-16, Complaint # IL-45589-LO, related to resident's rights.
Log # 025345-16, CIS # 2603-000031-16, related to alleged staff to resident abuse.
Log # 030603-16, CIS # 2603-000036-16, related to alleged staff to resident abuse.
Log # 023090-16, CIS # 2603-000026-16, related to alleged staff to resident abuse.
Log # 028925-16, CIS # 2603-000033-16, related to alleged staff to resident abuse.
Log # 023736-16, CIS # 2603-000027-16, related to alleged staff to resident abuse.
Log # 027124-16, CIS # 2603-000032-16, related to alleged staff to resident abuse.
Log # 019885-16, CIS # 2603-000016-16, related to alleged staff to resident abuse.
Log # 021962-16, CIS # 2603-000024-16, related to alleged resident to resident abuse.
Log # 020856-16, CIS # 2603-000021-16 related to resident's suicidal attempt.

During the course of the inspection, the inspector(s) spoke with the Administrator, Resident Care Coordinator, RAI Coordinator, Physician, Physiotherapist, two Registered staff members, five Personal Support Workers and one family member.

The inspector(s) also conducted a tour of the home, observed residents and care provided to them, observed resident to resident and staff to resident interactions, reviewed clinical records, relevant meeting minutes and policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.

2 WN(s)
0 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were collaborated, consistent with and complemented each other.

A) Clinical record review for a certain resident stated that a certain assessment completed post an incident on a certain date described this resident as oriented.

B) In an interview staff stated that the same resident was confused, and would not be oriented to time or place. The staff member reviewed the specified assessment and said that the information in this assessment was wrong, this information did not reflect the resident's status before or after the incident.
The staff member reviewed a different assessment for the resident where it was stated that the resident's cognitive level was severely impaired.

C) In an interview another staff member acknowledged that the assessments were inconsistent and did not complement each other.
The staff member said that the expectation would be for staff that were involved in the resident care to collaborate with each other so that their assessments are integrated, consistent and complemented each other.

During this inspection this non-compliance was found to have a severity level of actual harm/risk, the scope was isolated and a previous Written Notification was issued in an unrelated area. [s. 6. (4) (a)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (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. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee has failed to ensure that residents were not neglected by the licensee or staff.

Under the Long-Term Care Homes Act, 2007, and Regulation 79/10, neglect was defined as 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.

A) A review of a Critical Incident Systems report stated that on June 17, 2016, a specific resident had an incident. Resident was transferred to the Emergency Department and received treatment. Resident passed away on a later date due to complications of the incident.

B) Clinical record review for this resident and staff interviews showed that the resident's plan of care was not implemented prior to the incident. After the incident staff noted and documented a change in the resident's health condition, this change was not reported to the resident's physician. Specific staff expectation was that the physician would be called when a change in condition was identified.

C) Clinical record review for this resident and staff interviews showed that the resident had similar incidents before this specific incident. Staff member acknowledged that no interventions were put in place after the original incident to prevent further similar incidents.

D) A certain staff member reviewed clinical record for this resident and said that they would have expected staff to call physician and report changes to resident status. They also shared that the expectations would be that resident's incidents would be discussed and interventions put in place to reduce the risk for future similar incidents and injuries associated with that.

The licensee has failed to ensure that the resident was not neglected by staff when staff failed to update certain interventions to prevent certain incidents by the resident. Staff failed to inform Physician of actual changes in the resident condition that may have resulted in actual harm of the resident.

During this inspection this non-compliance was found to have a severity level of actual

harm/risk, the scope was isolated and this non-compliance was issued previously in a similar area as a:
Written Notification and Voluntary Plan of Correction on August 4, 2016, Inspection # 2016_325568_0015.
Written Notification and Compliance Order on March 17, 2014, Inspection # 2014-202165-0006. [s. 19. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 24th day of February, 2017

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ALI NASSER (523)
Inspection No. / No de l'inspection :	2016_262523_0040
Log No. / Registre no:	019479-16, 020115-16, 031240-16
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 24, 2017
Licensee / Titulaire de permis :	CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED 264 NORWICH AVENUE, WOODSTOCK, ON, N4S-3V9
LTC Home / Foyer de SLD :	CARESSANT CARE FERGUS NURSING HOME 450 QUEEN STREET EAST, FERGUS, ON, N1M-2Y7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CATHY COOK

To CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Order / Ordre :

The licensee shall ensure that staff involved in the residents care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Grounds / Motifs :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident so that their assessments were collaborated, consistent with and complemented each other.

A) Clinical record review for a certain resident stated that a certain assessment completed post an incident on a certain date described this resident as oriented.

B) In an interview staff stated that the same resident was confused, and would not be oriented to time or place. The staff member reviewed the specified assessment and said that the information in this assessment was wrong, this information did not reflect the resident's status before or after the incident.
The staff member reviewed a different assessment for the resident where it was stated that the resident's cognitive level was severely impaired.

C) In an interview another staff member acknowledged that the assessments were inconsistent and did not complement each other.
The staff member said that the expectation would be for staff that were involved in the resident care to collaborate with each other so that their assessments are integrated, consistent and complemented each other.

During this inspection this non-compliance was found to have a severity level of actual harm/risk, the scope was isolated and a previous Written Notification was issued in an unrelated area. [s. 6. (4) (a)]
(523)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2017

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (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. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee shall ensure that residents are not neglected by the licensee or staff.
The licensee shall complete a review of the falls prevention program and ensure that residents are assessed post falls and their plan of care is updated accordingly.
The licensee shall ensure that the physician is called and informed at the time there is a change in the resident status.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were not neglected by the licensee or staff.

Under the Long-Term Care Homes Act, 2007, and Regulation 79/10, neglect was defined as 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.

A) A review of a Critical Incident Systems report stated that on June 17, 2016, a specific resident had an incident. Resident was transferred to the Emergency Department and received treatment. Resident passed away on a later date due to complications of the incident.

B) Clinical record review for this resident and staff interviews showed that the resident's plan of care was not implemented prior to the incident. After the incident staff noted and documented a change in the resident's health condition, this change was not reported to the resident's physician. Specific staff

expectation was that the physician would be called when a change in condition was identified.

C) Clinical record review for this resident and staff interviews showed that the resident had similar incidents before this specific incident. Staff member acknowledged that no interventions were put in place after the original incident to prevent further similar incidents.

D) A certain staff member reviewed clinical record for this resident and said that they would have expected staff to call physician and report changes to resident status. They also shared that the expectations would be that resident's incidents would be discussed and interventions put in place to reduce the risk for future similar incidents and injuries associated with that.

The licensee has failed to ensure that the resident was not neglected by staff when staff failed to update certain interventions to prevent certain incidents by the resident. Staff failed to inform Physician of actual changes in the resident condition that may have resulted in actual harm of the resident.

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Written Notification and Voluntary Plan of Correction on August 4, 2016, Inspection #
2016_325568_0015.
Written Notification and Compliance Order on March 17, 2014, Inspection # 2014-202165-0006. [s. 19. (1)]

(523)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 24th day of February, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Ali Nasser

Service Area Office /
Bureau régional de services : London Service Area Office