Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 27, 2020	2020_800532_0007	020544-19, 020546-19, 020549-19, 020552-19, 020554-19, 024037-19, 001931-20, 003534-20	Follow up

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

NUZHAT UDDIN (532), KATHERINE ADAMSKI (753), TAWNIE URBANSKI (754)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): February 24-27, March 2-4, 2020.

The following intakes were completed in this Follow-up (FU) inspection:
Log # 001931-20 CI# 2603-000004-20 and Log # 003534-20 CI # 2603-000008-20 related to alleged abuse.
Log # 024037-19, Follow-up (FU) related to falls prevention.
Log # 020544-19, FU related to qualification of personal support workers.
Log # 020546-19, FU related to abuse.
Log # 020549-19, FU related to bathing.
Log # 020552-19, FU related to reporting to the Director.
Log # 020554-19, FU related to complaint process.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), acting Director of Care, Associate Director of Care (ADOC), Consultant, Nurse Coordinator, Activity Coordinator, Physiotherapist (PT), Physiotherapist Assistant (PTA), Behavioural Support Ontario (BSO), Registered Nurses, (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs) Housekeeper, family members and residents.

The inspectors also toured resident home areas, observed resident care provision and resident staff interaction, reviewed relevant residents' clinical records, policies and procedures, and training records pertaining to the inspection.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Sufficient Staffing

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

- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 101. (1)	CO #012	2019_727695_0025	754
LTCHA, 2007 S.O. 2007, c.8 s. 19.	CO #006	2019_727695_0025	532
LTCHA, 2007 S.O. 2007, c.8 s. 24.	CO #007	2019_727695_0025	532
O.Reg 79/10 s. 33. (1)	CO #002	2019_727695_0025	753
O.Reg 79/10 s. 47.	CO #010	2019_727695_0025	753
O.Reg 79/10 s. 49. (1)	CO #001	2019_793743_0020	754

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	Légende 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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

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

A Critical incident was submitted to the Ministry of Long-Term Care (MLTC) related to an incident of alleged abuse of a resident by staff.

The investigation notes determined that a staff was aware a specified resident had sustained injuries as a result of improper care but did not report the incident.

Investigation statement notes from the charge nurse stated that they were not informed until the next shift.

The ED confirmed that the staff was aware of the injuries to the identified resident but did not report the incident and related injuries until the next shift.

The license has failed to ensure that a person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director; improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it is based to the Director; improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident, to be implemented voluntarily.

WN #2: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that care set out in the plan of care in relation to physiotherapy treatment was provided to the identified residents as specified in their plan of care.

During an interview related to a follow-up inspection, an identified resident stated that they were upset that they were not receiving physiotherapy treatments as outlined in their plan of care due to staff availability and this was impacting their activities of daily living.

Record review of the care plan for three other identified residents stated that they required physiotherapy treatment two to three times per week.

The Therapy Minutes Report documented that the residents had not received physiotherapy treatment two to three times per week, during the identified weeks as stated in the plan of care.

The PT stated that when the PTA or PT was off sick, there was no staff relief to provide coverage and they would try to make up the day later in the week. They also stated that if the PTA or PT was on extended leave, such as vacation, there was no relief staff to provide coverage. Both the PT and PTA were on vacation in December and there was no relief coverage in the home.

The PT stated that in the past, the restorative care program had supported the physiotherapy team with resident’s treatment but the home had not had a restorative care program since 2019.

The DOC confirmed that currently, the home did not have a restorative care program in place.

The licensee has failed to ensure that care set out in the plan of care in relation to physiotherapy was provided to the residents as specified in the plan.

2. A CI was submitted to the ministry of long-term care (MLTC) related to alleged abuse of a resident by staff.

The Minimum Data Set/Resident Assessment Instrument (MDS/RAI) indicated that the identified resident required two or more staff for all activities of daily living.

A staff member indicated that the resident required two staff for activities of daily living, however, they provided the care independently which resulted in injury to the resident.

The ED confirmed that the care was not provided as set out in the plan of care and the resident sustained injuries as a result.

The licensee has failed to ensure that the care set out in the plan of care was provided to resident as specified in the plan. (532) [s. 6. (7)]

Issued on this 2nd day of June, 2020

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

Original report signed by the inspector.