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

Central West District
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Original Public Report

Report Issue Date: April 24, 2024	
Inspection Number: 2024-1242-0002	
Inspection Type: Proactive Compliance Inspection	
Licensee: Caressant-Care Nursing and Retirement Homes Limited	
Long Term Care Home and City: Caressant Care Arthur Nursing Home, Arthur	
Lead Inspector Kailee Bercowski (000734)	**Inspector Digital Signature**
Additional Inspector(s) Yami Salam (000688)	

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: April 2-4, 9-12, and 15-16, 2024
The inspection occurred offsite on the following date: April 5, 2024

The following intake was inspected:
- Intake: #00112415 - Proactive Compliance Inspection

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

Skin and Wound Prevention and Management
Resident Care and Support Services
Food, Nutrition and Hydration
Residents' and Family Councils
Medication Management

Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management
Falls Prevention and Management

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: O. Reg. 246/22, s. 168 (2) 6.
Continuous quality improvement initiative report
s. 168 (2) The report required under subsection (1) must contain the following information:
6. A written record of,
i. the actions taken to improve the long-term care home, and the care, services, programs and goods based on the documentation of the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act, the dates the actions were implemented and the outcomes of the actions,
ii. any other actions taken to improve the accommodation, care, services, programs, and goods provided to the residents in the home's priority areas for quality

improvement during the fiscal year, the dates the actions were implemented and the outcomes of the actions,
iii. the role of the Residents' Council and Family Council, if any, in actions taken under subparagraphs i and ii,
iv. the role of the continuous quality improvement committee in actions taken under subparagraphs i and ii, and
v. how, and the dates when, the actions taken under subparagraphs i and ii were communicated to residents and their families, the Residents' Council, Family Council, if any, and members of the staff of the home.

The licensee had initially failed to ensure the continuous quality initiative report for the fiscal year of 2022-2023 contained the following elements required by Ontario Regulations 246/22 s. 168 (2) (6):
A written record of,
i. the actions taken to improve the long-term care home, and the care, services, programs and goods based on the documentation of the results of the survey taken during the fiscal year under clause 43 (5) (b) of the Act, the dates the actions were implemented and the outcomes of the actions,
ii. any other actions taken to improve the accommodation, care, services, programs, and goods provided to the residents in the home's priority areas for quality improvement during the fiscal year, the dates the actions were implemented and the outcomes of the actions,
v. how, and the dates when, the actions taken under subparagraphs i and ii were communicated to residents and their families, the Residents' Council, Family Council, if any, and members of the staff of the home.

Rationale and Summary
At the time of inspection, the home's Executive Director indicated the Continuous Quality Improvement report from the 2022-2023 fiscal year posted on the home's

website did not contain the legislated components listed above. They indicated they had documentation of the required actions having been completed, but those were not included in the report on the website.

On April 15, 2024, an updated report was noted on the home's website, reflecting the home's written documentation pertaining to the legislated components.

The non-compliance was determined remedied prior to the inspection conclusion. The Inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

Sources: Caressant Care Nursing Home's Quality Report 2023; Interview with the home's Executive Director.
[000734]

Date Remedy Implemented: April 15, 2024

WRITTEN NOTIFICATION: General Requirements for Programs

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 34 (2)
General requirements
s. 34 (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented.

The licensee has failed to ensure that any actions taken with respect to a resident under a program, including interventions and the resident's responses to

interventions, were documented.

Rationale and Summary
During the course of inspection, a concern was raised about the timing of a resident's toileting care.

A review of a resident's clinical records indicated that the documentation occurred prior to when all the care was expected to be completed.

A Personal Support Worker (PSW) stated that they were not aware of the resident's routine for the specific care task as indicated in their plan of care. They also stated that their Point of Care documentation system did not provide them direction on the timing and frequency of the continence care required by the resident.

The Director of Care (DOC) stated that there was no documentation to verify that staff are adhering to the resident's plan of care.

This failure to document the provision of care put the resident at risk of not receiving assistance at the designated times outlined in their plan.

Sources: Resident's clinical records, interview with the home's DOC and other staff. [000688]

WRITTEN NOTIFICATION: Menu planning

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 77 (2) (c)
Menu planning
s. 77 (2) The licensee shall ensure that, prior to being in effect, each menu cycle,

(c) is approved for nutritional adequacy by a registered dietitian who is a member of the staff of the home, and who must take into consideration,
(i) subsection (1),
(ii) the residents' preferences, and
(iii) current Dietary Reference Intakes (DRIs) relevant to the resident population. O. Reg. 246/22, s. 390 (1).

The licensee has failed to ensure the home's Winter Spring 2023 menu cycle was reviewed for nutritional adequacy by the home's in house dietitian prior to being put into effect.

Rationale and Summary
The home's Winter Spring 2023 menu cycle was provided to the home in the beginning of October 2023, and it was put into effect on November 6, 2023.

Multiple changes were made to the menu between October 2023 and January 2024.

The home's Registered Dietitian (RD) did not review the menu for nutritional adequacy until January 18, 2024.

When the menu cycle was not reviewed for nutritional adequacy by the home's RD prior to being put in effect, residents were at risk of receiving a menu that was not sufficiently varied or nutritionally adequate.

Sources: Interviews with the home's Food & Nutrition Manager and Registered Dietitian; 2023 Winter Spring Menu Evaluation, and other records.
[000734]

WRITTEN NOTIFICATION: Infection prevention and control program

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure that the infection prevention and control (IPAC) standard issued by the Director was followed by staff.

The Infection Prevention and Control (IPAC) Standard for Long Term Care Homes revised September 2023 (IPAC Standard) section 10.2 (c) related to resident hand hygiene stated that the hand hygiene program for residents shall include assistance to residents to perform hand hygiene before meals.

Rationale and Summary
During the inspection, Inspector #000688 observed a lunch meal service and snack service.

During the observations, it was noted that multiple residents were not offered hand hygiene before their meal or snack.

Multiple PSWs stated that they forgot to provide hand hygiene to the residents that they assisted to the dining room, or offered a snack.

The home's IPAC lead stated that staff were expected to offer hand hygiene for the residents prior to eating.

By not performing hand hygiene, there was an increased risk of disease transmission among the residents and staff.

Sources: Lunch and snack observation, Hand Hygiene – Residents Policy ID: LTC-IPAC-S12-20.0. Reviewed date: October 27, 2023, Interviews with the home's IPAC lead and other staff.

[000688]