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
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: May 19, 2023

Inspection Number: 2023-1108-0003

Inspection Type:
Critical Incident System

Licensee: Caressant-Care Nursing and Retirement Homes Limited

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

Lead Inspector	**Inspector Digital Signature**
April Racpan (218)	April Joy Racpan Digitally signed by April Joy Racpan Date: 2023.05.19 12:42:27 -04'00'

Additional Inspector(s)

INSPECTION SUMMARY

The inspection occurred onsite on the following dates: May 10-12 and 15-16, 2023.

The following intakes were inspected:
- Intake: #00022837 related to prevention of abuse and neglect
- Intake: #00084884 related to an injury of unknown cause
- Intake: #00023012 related to falls prevention and management

The following intakes related to falls prevention and management were completed in this inspection:
- Intake: #00020776
- Intake: #00084629

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

Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: REPORTING CERTAIN MATTERS TO DIRECTOR

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

Non-compliance with: FLTCA, 2021 s. 28 (1) 1.

The licensee has failed to ensure that when staff had reasonable grounds to suspect that improper care of a resident had occurred, that they immediately reported the suspicion and information to the Director in accordance with section (s.) 28 (1) of the Fixing Long-Term Care Act (FLTCA), 2021. Pursuant to Ontario Regulation (O. Reg.) 246/22 s. 154 (3), the licensee is vicariously liable for staff members failing to comply with FLTCA, 2021 s. 28 (1).

Rationale and Summary

A Registered Nurse (RN) witnessed an incident where they alleged that a Personal Support Worker (PSW) provided improper care towards a resident that resulted in an injury.

The RN did not immediately provide the Director of Care (DOC) with information related to the allegation of improper care. The Director was not notified of the alleged incident until the following day.

There was minimal risk of harm when the Director was not notified immediately of the suspicion of improper care as it may have delayed actions by the Director.

Sources: Critical Incident (CI) report, "Zero Tolerance of Abuse and Neglect Procedure" last reviewed April 2022, interviews with the RN and DOC.

[218]

COMPLIANCE ORDER CO #001 TRANSFERRING AND POSITIONING TECHNIQUES

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

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

Non-compliance with: O. Reg. 246/22 s. 40.

The licensee shall:

1) Complete a weekly audit of PSW staff for the safe application of positioning techniques when assisting residents who utilize a walker as a mobility device.

2) The audits shall be completed for a minimum of four weeks, or until compliance has been achieved.

3) The audits shall be documented and the record maintained to include: the name(s) of the person completing the audit, the name of the person(s) being audited, and any corrective actions taken if any.

Grounds

Non-compliance with: O. Reg. 246/22 s. 40.

The licensee has failed to ensure that a PSW used safe transferring and positioning techniques when they assisted a resident to ambulate.

Rationale and Summary

A resident ambulated with a walker and required some level of assistance by staff when they walked from one location of the unit to another. Due to their mobility status, staff were expected to safely assist the resident by standing and providing support at the resident's side while they ambulated.

The resident declined to go to the dining room for a meal service. The PSW stated that the resident was not feeling well but they still wanted to persuade the resident to attend. Despite the resident's refusal, the PSW proceeded to assist them to walk towards the dining room. Instead of assisting the resident at their side, the PSW placed themselves in a different position while the resident continued to physically refuse.

An RN witnessed the incident and said they saw the resident fall to the ground. The PSW acknowledged that they should have applied proper positioning techniques when they assisted the resident to walk. Not doing so resulted in them not being able to assist the resident when they fell.

The DOC stated that the PSW demonstrated unsafe positioning techniques when the PSW physically insisted for the resident to walk while the resident adamantly refused.

As a result of this incident, the resident experienced actual harm that resulted in a significant change to their status when they were not provided with safe transferring and positioning assistance by the PSW.

Sources: CI report, resident's clinical records, plan of care, RAI-MDS assessments, progress notes, home's investigation notes, interviews with the PSW, RN, the DOC, and other staff.

[218]

This order must be complied with by June 30, 2023

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
e-mail: MLTC.AppealsCoordinator@ontario.ca

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.