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
Mar 15, 2021	2021_643111_0004	021011-20, 021445-20, 023494-20, 025848-20	Critical Incident System

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 Lindsay Nursing Home
240 Mary Street West Lindsay ON K9V 5K5

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

LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): February 12, 17 to 19, 2021.

There were three critical incidents and one follow-up inspected concurrently during this inspection:
-two CIR's related to falls with injury.
-one CIR related to resident to resident abuse.
-one follow-up to Compliance Order #001.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), The Director of Care (DOC), Resident Care Coordinator (RCC), Registered Nurse (RN), Personal Support Workers (PSWs), Resident Assistant (RA) and residents.

During the course of the inspection, the inspector toured the home, observed residents, resident rooms, observed a meal service, reviewed health records, falls prevention committee meeting minutes and reviewed the following policies: Falls Prevention Program and Responsive Behaviours.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 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
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2020_643111_0017	111

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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

The licensee has failed to ensure that the home is a safe and secure environment for its residents.

On various dates and times, identified visitors were observed in a specified area, sitting less than two metres apart and not wearing a mask. Directive #3 directs all staff and visitors to comply with universal masking when not in contact with residents and during their breaks, may remove their masks but remain two metres away from each other. Failing to implement Directive #3 can lead to potential exposure to other essential visitors.

Sources: observations and COVID-19 Directive #3 for Long-Term Care Homes under the Long- Term Care Homes Act, 2007, Issued under Section 77.7 of the Health Protection and Promotion Act (HPPA), R.S.O. 1990, c. H.7 (dated December 7, 2020).

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 the home is a safe and secure environment for its residents, 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).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #002, as specified in the plan related to falls.

Resident #002 had sustained an unwitnessed fall in a specified area, was transferred to hospital and diagnosed with an injury. The resident had a prior history of falls within the same specified area and the same circumstances.The resident's plan of care identified specified fall prevention interventions that were observed by the Inspector, to not be in place. A PSW confirmed a specified fall prevention intervention had not been put in place. Failing to implement fall prevention interventions could lead to additional falls with injury.

Sources: CIR, progress notes, care plan of resident #002, observation of resident #002 and interview of staff.

2. The licensee has failed to ensure that the care set out in the plan of care was provided to resident #003, as specified in the plan related to falls.

Resident #003 had identified falls prevention interventions indicated in their plan of care due to risk of falls. The resident had sustained a number of falls over a specified period. A number of the falls occurred when two of the falls prevention interventions were not implemented. The resident was also observed by the Inspector with specified falls prevention interventions not implemented. Failing to implement falls prevention interventions, increases the risk of injury to the resident.

Sources: progress notes, care plan of resident #003, observation of resident #003, observation of the resident's room and interview of staff.

3. The licensee has failed to ensure that resident #003 was being reassessed and the plan of care was being revised, when care set out in the plan had not been effective and different approaches had been considered in the revision of the plan of care.

Resident #003 had sustained a number of falls during a specified period, a number of the falls occurred from their mobility aid, and a number of their falls occurred from their bed, with near miss incidents. A specified alarming device was used, despite a number of the falls occurring where the device was determined to be ineffective, and a different alarming device was not considered until a number of falls had occurred and no other interventions were considered when the resident continued to fall. A staff member confirmed that no other falls prevention interventions were considered, despite the resident continuing to fall. Failing to consider additional falls prevention interventions can contribute to ongoing falls and risk of injury.

Sources: progress notes, care plan of resident #003 and interview of staff.

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 the care set out in the plan of care, is provided to the resident as specified in the plan and to ensure, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

A PSW was observed by the Inspector leaving a resident's room on contact/droplet precautions without proper removal of their PPE. Another staff member was also observed leaving the same resident room without disposal of PPE. Another resident had signage on their door indicating they were on droplet precautions and the Executive Director (ED) confirmed the resident was supposed to be on both contact and droplet precautions. Staff failing to implement the IPAC program can lead to spread of infections.

Sources: observations and interview of staff.

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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

The licensee has failed to ensure that when resident #003 had fallen, the resident had been assessed and a post-fall assessment had been conducted using a clinically appropriate assessment instrument, that is specifically designed for falls.

During a specified period, resident #003 had sustained a number of falls a number of the falls had no post-fall assessments completed. In addition, on each post fall assessment form that was completed, only a number of the assessments had actions indicated to prevent a recurrence. RCC #102 confirmed the post fall investigation was to be completed after each fall as the post-fall assessment instrument and should have included actions taken to prevent a recurrence on each form.

Sources: progress notes, post fall investigations for resident #003 and interview of staff.

Issued on this 17th day of March, 2021

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

Original report signed by the inspector.