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

London District
130 Dufferin Avenue, 4th Floor
London, ON, N6A 5R2
Telephone: (800) 663-3775

Original Public Report

Report Issue Date: July 9, 2024
Inspection Number: 2024-1226-0003
Inspection Type: Complaint Critical Incident
Licensee: Caressant-Care Nursing and Retirement Homes Limited
Long Term Care Home and City: Caressant Care on Bonnie Place, St Thomas

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 3, 4, 5, and 8, 2024.

The following intake(s) were inspected:

- Intake: #00106855/Complaint related to resident care and allegations of neglect;
- Intake: #00108739/Critical Incident (CI) report #2730-000003-24 related to an outbreak;
- Intake: #00113053/CI #2730-000006-24 related to staff to resident abuse;
- Intake: #00115164/CI #2730-000011-24 related to an outbreak;
- Intake: #00115162/CI #2730-000010-24 related to an outbreak.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect

INSPECTION RESULTS

WRITTEN NOTIFICATION: Complaints Procedure — Licensee

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 26 (1) (c)
Complaints procedure — licensee
s. 26 (1) Every licensee of a long-term care home shall,
(c) immediately forward to the Director any written complaint that it receives concerning the care of a resident or the operation of a long-term care home in the manner set out in the regulations, where the complaint has been submitted in the format provided for in the regulations and complies with any other requirements that may be provided for in the regulations.

The licensee has failed to immediately forward to the Director a written complaint that it received concerning the care of a resident.

Rationale and Summary
The Executive Director received an email complaint related to the care of a resident. The written complaint had not been submitted to the Director.

The Director of Care (DOC) confirmed that the complaint related to the care of the resident had not been submitted to the Director.

There was low risk to the resident by not reporting to the Director.

Sources: Review of the home's complaints binder, Long-Term Care Homes.net; and interviews with the DOC and the Executive Director. [522]

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 1.
Reporting certain matters to Director
s. 28 (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.

The licensee has failed to immediately report to the Director improper treatment or care of a resident that resulted in a risk of harm to the resident.

Rationale and Summary
The Executive Director received an email complaint related to the care of a resident. The allegation of improper care had not been reported to the Director.

The Director of Care (DOC) confirmed that the allegation of improper care had not been reported to the Director.

There was low risk to the resident by not reporting to the Director.

Sources: Review of the home's complaints binder, Long-Term Care Homes.net; and interviews with the DOC and the Executive Director. [522]

WRITTEN NOTIFICATION: Responsive Behaviours

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that actions taken to respond to the needs of a resident's behaviours, including interventions and the resident's responses to interventions were documented.

Rationale and Summary
A resident had a history of responsive behaviours as evidenced by the refusal to follow directions. If the resident's behaviours escalated, staff were to allow the resident space to calm down and re-approach the resident later.

A Registered Nurse (RN) had documented that a resident had refused all care that shift, as well as their meal.

On the same shift, Personal Support Worker (PSW) #111 had documented that the resident had refused continence care, there was no documentation of the number of times PSW #111 had reapproached the resident to provide care.

PSW #111 had documented early in the shift that the resident had not displayed any

behaviours that shift. There was no documentation later in the shift related to the resident's refusal to come for their meal and refusal of continence care.

PSW #111 stated when the resident refused care they reapproached the resident and brought the resident their meal and snacks if the resident would not come to the dining room. PSW #111 stated although they would reapproach the resident several times, they did not document the reapproaches in point of care.

RN #108 acknowledged their charting did not reflect the multiple approaches by staff to offer meals and continence care to the resident.

There was low risk to the resident by staff not documenting the reapproaches to provide care.

Sources: Review of a complaint, the resident's clinical record; and interviews with PSW #111, RN #108 and the Director of Care. [522]

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 (8)
Infection prevention and control program
s. 102 (8) The licensee shall ensure that all staff participate in the implementation of the program, including, for greater certainty, all members of the leadership team, including the Administrator, the Medical Director, the Director of Nursing and Personal Care and the infection prevention and control lead. O. Reg. 246/22, s. 102 (8).

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

Rationale and Summary
During an observation, the inspector noted there was additional precautions signage posted at a resident's doorway, which indicated specific personal protective equipment (PPE) that staff were to wear when providing care to the resident.

Personal Support Workers (PSW) #109 and #110 were seen completing care for the resident without the required PPE.

PSW # 109 acknowledged they should have worn the proper PPE when they were providing care to the resident.

The Director of care (DOC) acknowledged that the staff members did not follow infection precautions for the resident when the required PPE was not applied.

When staff did not wear the correct PPE when caring for the resident, there was a risk that infection could have spread.

Sources: Staff interviews, resident and staff observations. [705241]

WRITTEN NOTIFICATION: Dealing With Complaints

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 108 (2)
Dealing with complaints

s. 108 (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

The licensee has failed to ensure that a documented record was kept in the home regarding a written complaint that was made to the Executive Director regarding the care of a resident.

Rationale and Summary
A complaint was made to the Ministry of Long-Term Care regarding the care of a resident.

The Executive Director (ED) also received an email complaint related to care of the resident.

There was no documentation that included:
(a) the nature of the written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;

(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant.

The ED stated they could not recall the incident and could not find a Client Service Response form or any documentation related to the complaint.

There was moderate risk to the resident by not documenting the complaint as there was no record of what happened, and who was involved.

Sources: Review of a complaint, a resident's clinical record, the home's complaints binder, the home's "Client Service Response - Process to Address Concern/Complaint" policy LTC-Admin-S12-10.0 with a review date of July 27, 2023, and interviews with the Director of Care and the ED. [522]