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 18, 2022	2021_815623_0020	005983-21, 006048-21, 009013-21, 009188-21	Complaint

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 on McLaughlin Road
114 McLaughlin Road Lindsay ON K9V 6L1

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

SARAH GILLIS (623)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 21, 22, 25-29, November 1-5, 9 and 10, 2021

The following intakes were inspected concurrently:
Log #005983-21 complaint related to plan of care and complaint process not followed.
Log #006048-21 complaint related to an allegation of staff to resident neglect.
Log #009013-21 an anonymous complaint related to staffing, equipment lacking, bathing.
Log #009188-21 an anonymous complaint related to staffing, bathing and plan of care.

non-compliance identified for s. 23 (2) will be reflected in CIR report #2021_815623_0021 inspected concurrently.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Director of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Occupational Therapist (OT), Housekeepers (HSKP), Administrative Assistant (AA), Ward Clerk, Clinical Practice Lead - Caressant Care, Regional Director of Operations - Caressant Care, residents and families.

The Inspector also reviewed the licensee's internal records, resident health care records, housekeeping services, applicable policies, observed Infection Prevention and Control practices, the delivery of resident care and services, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Skin and Wound Care

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

- **6 WN(s)**
- **6 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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 :

1. The licensee failed to ensure that the home is a safe and secure environment for its residents when observations revealed the improper use of the surgical procedure masks by staff.

The Chief Medical Officer of Health (CMOH) implemented Directive #3 which has been issued to long-term care homes and sets out specific precautions and procedures that homes must follow to protect the health of residents and address the risks of an outbreak of COVID-19 in long-term care homes. The version of Directive #3 dated effective July 16, 2021, all staff and visitors must always comply with universal masking and must wear a medical mask for the entire duration of their shift/visit. Staff are required to comply with universal masking at all times, even when they are not delivering direct patient care, including in administrative areas. During their breaks, to prevent staff-to-staff transmission of COVID-19, staff must remain two metres away from others at all times and be physically distanced before removing their medical mask for eating and drinking. Masks must not be removed when staff are interacting with residents and/or in designated resident areas.

Observations throughout the inspection revealed that on multiple occasions various staff members not wearing a universal mask in all home areas including administrative areas. Staff were observed taking lunch breaks in the multipurpose room, seated at the same table, unmasked and not two meters apart.

The Executive Director who was also the IPAC Lead for the home, indicated that the expectation was that all staff would comply with universal masking at all times in accordance with Directive #3. Staff who where were on a break should maintain two meters distance when unmasked, eating or drinking.

The lack of adherence to Directive #3 related to universal masking and the proper use of surgical/procedure masks by staff, presented an actual risk of exposing the residents to COVID-19.

Sources: Directive #3 (version effective as of July 16, 2021), observations throughout the home, interview with Executive Director. [s. 5.]

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 by ensuring that the home is safe and secure environment for its residents, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that for the resident exhibiting altered skin integrity, the equipment, supplies, devices and positioning aids are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing.

A complaint was received by the Director indicating that resident #003 had been admitted to the home and the resident required specific equipment so that the staff could provide care, this equipment was not available at admission, and some of it took several months to obtain. The home lacked the proper equipment to care for the resident, including a specific bed, therapeutic mattress, specific transfer equipment and personal care equipment. The complainant indicated that it was known prior to admission that resident #003 had a healed stage 3 wound in an identified area and the skin was fragile. The staff were unable to lift the resident from the bed and unable to bathe the resident in a tub because the home did not have the proper equipment. The resident was provided a regular mattress, there was no therapeutic mattress available. The complainant also indicated that the resident could not be transferred for personal care as there was no safe transfer equipment available. The resident required the use specific personal equipment but this was not available. The regular equipment caused pressure, which

resulted in the healed wound reopening.

During an interview, resident #003 indicated they were unable to get out of bed or get into a bath for several months after being admitted to the home because there was not appropriate equipment available to transfer them. The resident indicated that they were on a regular mattress and had to use personal care equipment that did not meet their needs, as a result their healed wound reopened.

Clinical records indicate that the resident was admitted on a specified date. Review of the licensee's purchase orders indicated that a therapeutic surface was ordered but did not arrive in the home for resident #003 until three weeks later. A specific lifting device was not ordered until six weeks after admission and did not arrive in the home for six weeks. Other specific personal care equipment was not ordered or available for resident #003.

RPN #106 indicated that skin assessments for resident #003 were completed on admission and weekly thereafter. On admission the skin was healed but within 17 days, the healed area was presenting as a stage 2 ulcer. The RPN indicated they had requested a therapeutic mattress be ordered prior to the admission of resident #003 based on their wound history. The admission was delayed by a few days but only long enough for the home to repair a bed that would accommodate the resident, but did not have a therapeutic surface available. The home also did not have the proper transfer equipment to lift the resident with for many months, care was a challenge.

The Executive Director (ED) indicated that they were not in the home when the resident was admitted. Once becoming aware of the equipment that was required, the ED advocated for the acquisition. The ED could not speak to what occurred prior.

When the licensee failed to ensure that for resident #003 who was exhibiting altered skin integrity, the equipment, supplies, devices and positioning aids were readily available at the home as required to relieve pressure, treat pressure ulcers or wounds and promote healing. This resulted in the reopening of a healed ulcer for the resident.

Source: resident interview, staff interviews, review of clinical records and equipment purchase order records. [s. 50. (2) (c)]

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 by ensuring that the resident who exhibits altered skin integrity, the equipment, supplies, devices and positioning aids are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents who require continence care products, have sufficient changes to remain clean, dry and comfortable.

A complaint was received by the Director which indicated that the home lacked supplies to care for the residents. The complainant indicated that residents are provided with one continence product per shift and the ability to obtain one additional. There is often not enough supplies to provide even one to each resident.

During the inspection, resident #008 was overheard complaining to the physician that they were upset with the lack of supplies in the home. Resident #008 stated that they have not had the right size of continence products for five days. The resident stated that staff are using a product that is too small because they have run out of supplies and as a result it is causing leaking and the resident’s pants are constantly wet. The resident indicated this was embarrassing and they wanted it looked into.

During an interview the Executive Director (ED) indicated they order continence products and only keep one weeks supply in the building. The ED indicated that the order had been placed and was supposed to arrive in the building on Monday. The order did not arrive as scheduled and they had already been running short over the weekend. The ED indicated they were not permitted to order additional supplies to have on hand in case of a break in supply chain. The ED indicated that staff would have to make do with what was available.

When the continence supplies were not received and the home did not have a back up supply available, residents were at risk of not maintaining their dignity and good skin integrity.

Sources: Staff interviews, resident interviews, email correspondence. [s. 51. (2) (g)]

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 by ensuring that residents who require continence care products, have a sufficient changes to remain clean, dry and comfortable, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (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; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(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; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a written complaint made to the licensee concerning

the care of a resident was investigated, resolved where possible and a response provided within 10 business days of the receipt of the complaint, and where the complaint alleged harm or risk of harm to one or more residents, the investigation commenced immediately.

A complaint was received by the Ministry of Long-term Care which indicated that the complainant had submitted a written complaint to the Executive Director (ED) of the home on a specified date, which alleged neglect of care for resident #001. The complainant indicated they had not received a response from the home, despite several requests by the complainant for follow-up from the ED.

Review of the licensee's internal records indicated that the written complaint was received on a specified date. Three weeks later, a follow-up email to the ED was written by the complainant requesting a response to the original complaint. The ED responded in writing stating they were working on the response. The complainant spoke to the RN expressing frustration over no response to their concerns. The complainant contacted the Director of Care (DOC), asking for answers to the original complaint. A written response from the ED was received by the complainant six weeks after the initial complaint. There were no documented records of the licensee's internal investigation into the allegations of neglect of care of resident #001.

The licensee failed to respond to a written complaint concerning the care of resident #001 within 10 business days and failed to investigate the allegation of neglect of care immediately.

When the ED failed to immediately investigate the allegation of neglect of care of resident #001 and did not respond to the written complaint within 10 business days, the resident was at risk of further neglect.

Sources: Internal records of complaints, resident #001 clinical records, complaints policy and staff interviews. [s. 101. (1) 1.]

2. The licensee failed to ensure that a documented record was kept in the home included; the nature of the written complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of action, time frames for actions to be taken and any follow-up action required, the final resolution, if any, every date on which any response was provided to the complainant and a description of the response and any response made by the complainant, when a complaint was received

on a specified date alleging neglect of care of resident #001.

Review of the licensee's internal records for complaints revealed there was no documented record of the initial complaint, any action taken by the licensee or any response to the complainant by the ED. There was a final response letter to the complainant in the complaints binder, but no other required documented records were available.

The Executive Director indicated they were unable to locate any documented records of the complaint including the initial written complaint or the licensee's investigation. The ED indicated they were not working in the home at the time of the complaint and were unable to provide insight into the complaint.

When the licensee failed to retain documented records of a written complaint alleging neglect of care of resident #001, there was no ability for the Inspector to determine the homes actions in response to the allegations and the outcome of the licensee's investigation.

Sources: Complaints record binder, staff interviews. [s. 101. (2)]

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 by ensuring that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with and by ensuring that a documented record is kept in the home, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director

Specifically failed to comply with the following:

s. 103. (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). O. Reg. 79/10, s. 103 (1).

Findings/Faits saillants :

1. The licensee failed to submit to the Director a corresponding written report documenting the response the licensee made to the complainant went a written complaint was received relating to a matter that the licensee reported to the Director under section 24 of the Act.

A Critical Incident Report (CIR) was submitted to the Director which indicated the Executive Director had received an email complaint from resident #001's family member indicating an allegation of abuse. The CIR indicated that an investigation was pending and the ED would forward a copy of the written complaint to the Director. The initial complaint was received but there was no further information including the response the licensee made to the complainant.

The licensee failed to submit to the Director a written report documenting the response the licensee made to the family of resident #001, for an allegation of abuse by the complainant.

Source: CIR, complaint record review, staff interview. [s. 103. (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 by ensuring that Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act. shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). O. Reg. 79/10, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 174.1 Directives by Minister

Specifically failed to comply with the following:

s. 174.1 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home. 2017, c. 25, Sched. 5, s. 49.

Findings/Faits saillants :

1. The licensee failed to carry out every operational policy that applies to the long-term care home related to randomized testing of fully immunized individuals.

Minister's Directive: COVID-19: Long-Term Care Home Surveillance Testing and Access to Homes Effective October 15, 2021 indicated that effective October 15, 2021 homes must undertake randomized testing of fully immunized individuals using rapid antigen tests, at an interval set out by the licensee.While licensees may select the randomized testing approach to be used, homes must do randomized testing on a weekly basis and cannot do the randomized testing on one static day of each week. Licensees should ensure that the results of the randomized testing are recorded and tracked for reporting, inspection and compliance purposes.

During an interview the Executive Director who was the IPAC Lead, indicated that the home had implemented weekly randomized testing as per the Directive #3, on October 15, 2021. During a separate interview RPN #105 indicated they were only asked to conduct randomized testing on October 15, 2021 and it was not communicated this was to be completed weekly. Testing was only completed on visitors to the home and not on staff including Agency staff.

Record review of randomized testing in the home revealed there had only been one day of randomized testing completed on October 15, 2021 and had not been completed since. The records confirmed that tests completed on that date were conducted on visitors to the home only.

When the home failed to follow the Ministers Directive effective October 15, 2021, for randomized testing of fully immunized against COVID-19 individuals, the home was at risk when staff, students, essential care givers, visitors, entered the home and potentially being unaware that they were experiencing a breakthrough COVID-19 infection, placing the residents at risk of contracting COVID-19.

Source: Minister's Directive: COVID-19: Long-Term Care Home Surveillance Testing and Access to Homes, Executive Director, RPN #106, COVID testing records. [s. 174.1 (3)]

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 by ensuring that the home shall carry out every operational or policy directive that applies to the long-term care home, to be implemented voluntarily.

Issued on this 25th day of March, 2022

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

Original report signed by the inspector.