



**Ministry of Health and
Long-Term Care**

**Inspection Report under
the Long-Term Care
Homes Act, 2007**

**Ministère de la Santé et des
Soins de longue durée**

**Rapport d'inspection sous la
Loi de 2007 sur les foyers de
soins de longue durée**

**Long-Term Care Homes Division
Long-Term Care Inspections Branch**

**Division des foyers de 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
May 7, 2018	2018_508137_0007	004889-18	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 Fergus Nursing Home
450 Queen Street East FERGUS ON N1M 2Y7

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

MARIAN MACDONALD (137)

Inspection Summary/Résumé de l'inspection



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

This inspection was conducted on the following date(s): March 7-9, 12-15, 19-23, 26-29, April 3-6, 9-10 and 13, 2018.

The following inspections were conducted concurrently during this Complaint inspection:

Log #004799-18, Follow up to an immediate compliance order related to Director of Nursing qualifications; Log #002325-18, Critical Incident System (CIS) #2603-000015-18; Log #001151-18, CIS #2603-000006-18; Log #004608-18, Complaint and Log #004224-18, Complaint related to alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Regional Director of Operations, Registered Staff, Personal Support Workers and an identified resident.

The Inspector also reviewed staff statements, Risk Management reports, Treatment Administration Records (TAR) and resident's clinical records.

**The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation**

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

1 WN(s)

1 VPC(s)

0 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:

1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).

2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

3. Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident. O. Reg. 79/10, s. 104 (1).

4. Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence. O. Reg. 79/10, s. 104 (1).

5. The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to make a report in writing to the Director under subsection 23 (2) of the Act, with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report.



In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report: 1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. 2. A description of the individuals involved in the incident, including, i. names of all residents involved in the incident, ii. names of any staff members or other persons who were present at or discovered the incident, and iii. names of staff members who responded or are responding to the incident. 3. Actions taken in response to the incident, including, i. what care was given or action taken as a result of the incident, and by whom, ii. whether a physician or registered nurse in the extended class was contacted, iii. what other authorities were contacted about the incident, if any, iv. whether a family member, person of importance or a substitute decision-maker of any resident involved in the incident was contacted and the name of such person or persons, and v. the outcome or current status of the individual or individuals who were involved in the incident. 4. Analysis and follow-up action, including, i. the immediate actions that have been taken to prevent recurrence, and ii. the long-term actions planned to correct the situation and prevent recurrence. 5. The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector. O. Reg. 79/10, s. 104 (1).

On an identified date, staff member # 141 reported an incident of alleged staff to resident abuse, with injury, to the Ministry of Health and Long Term Care (MOHLTC) Info-line, involving an identified resident.

Administrator #107 was present in the home on the identified date and was aware of the alleged incident but a Critical Incident System (CIS) report was not submitted to the Ministry of Health and Long Term Care (MOHLTC), related to an incident of alleged, suspected or actual staff to resident abuse, involving an identified resident, as per the legislative requirements.

During an interview, on an identified date, the same resident explained the details of the alleged incident to Inspector #137.

The licensee has failed to make a report in writing to the Director under subsection 23 (2) of the Act, with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report.



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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 to make a report in writing to the Director under subsection 23 (2) of the Act, with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report, to be implemented voluntarily.

Issued on this 7th day of May, 2018

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

Original report signed by the inspector.