Ministry of Health and Long-Term Care
Long Term Care Inspections Branch
Long Term Care Homes Inspection Division

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Order(s) of the Director

under the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

	☐ **Licensee Copy/Copie du Titulaire** ☒ **Public Copy/Copie Public**
Name of Director:	Karen Simpson
Order Type:	□ Amend or Impose Conditions on Licence Order, section 104 □ Renovation of Municipal Home Order, section 135 □ Compliance Order, section 153 □ Work and Activity Order, section 154 □ Return of Funding Order, section 155 X Mandatory Management Order, section 156 □ Revocation of Licence Order, section 157 □ Interim Manager Order, section 157
Intake Log # of original inspection (if applicable):	
Original Inspection #:	
Licensee:	Caressant Care Nursing and Retirement Homes Limited
LTC Home:	Caressant Care Fergus
Name of Administrator:	Charlie Warren

Background:

Caressant Care Fergus ("the home") is a long-term care home in Fergus, Ontario within the Waterloo Wellington Local Health Integration Network (LHIN). Caressant Care Nursing and Retirement Homes Ltd. ("the licensee") is licensed for 87 long-stay beds in the home.

On October 2, 2017, the Director under the *Long Term Care Homes Act, 2007* (LTCHA) directed the local placement coordinator to cease admissions to the home on the belief that there was a risk of harm to the health or well-being of residents in the home or persons who might be admitted as residents. This was based on findings from a follow-up inspection (2017_508137_0018) conducted on August 24, 2017, which resulted in a Director's Referral and five compliance Orders issued to the licensee, three of which had been re-issued multiple times previously. The cease of admissions was effective October 3, 2017 and continues to remain in effect.

Since June 2016, the licensee has repeatedly failed to comply with numerous requirements

under the LTCHA and Ontario Regulation 79/10 ("the Regulation"), including but not limited to:

- Regulation, s. 53(4), developing and implementing strategies for residents who exhibit responsive behaviours to respond to those behaviours;
- Regulation, s, 55, developing and implementing procedures and interventions to assist residents who are at risk of harm as a result of responsive behaviours and to minimize the risk of altercations between and among residents;
- LTCHA, s. 20(1), complying with the home's abuse policy;
- LTCHA, s. 23(1)(a)ii, alleged incidents of neglect not being immediately investigated;
- LTCHA, s. 24(1), immediately reporting to the Director; and
- LTCHA, s. 3(1)4 resident's rights to be properly groomed and cared for consistent with their needs.

Despite receiving multiple and repeated Compliance Orders from different inspections (2016_325568_0015 June 2016, 2016_262523_0038 October 2016, 2016_262523_0040 November 2016, 2017_508137_0018 August 2017, 2018_448155_0001 March 2018), the cease of admissions at the home and meetings with the Licensee in October and December 2017, the licensee has failed to achieve compliance with the LTCHA and Regulation. Based on this, the licensee has demonstrated a lack of understanding of what is required to address non-compliance, as well the inability to correct and sustain compliance.

Subsection 156(1) of the LTCHA states that the Director may order a licensee to retain, at the licensee's expense, one or more persons acceptable to the Director to manage or assist in managing the long-term care home.

Subsection 156(2) of the LTCHA states that an order may be made under this section if: (a) the licensee has not complied with a requirement under the LTCHA; and (b) there are reasonable grounds to believe that the licensee cannot or will not properly manage the long-term care home or cannot do so without assistance.

In addition, the Director has considered the Regulation, s. 299(1) and in particular 299(1)3, which requires the Director to take into account the licensee's history of compliance in any home, with requirements under the Act.

The Director is issuing this Mandatory Management Order (MMO) as the licensee has had an ongoing failure to comply with numerous requirements in the LTCHA and the Regulation which provide the Director with reasonable grounds to believe that the licensee cannot properly manage the long-term care home.

This belief is based on the ongoing and persistent non-compliance, including the re-issuance of

multiple Orders; the lack of understanding by the licensee of the compliance issues and the steps required to address and correct these serious issues; the scope and severity of the non-compliance found; the risks to residents in relation to the non-compliance found; and the ongoing instability in the home's senior leadership.

In addition, in accordance with section 299(1)3 of the Regulation, the Director has considered the multiple areas of non-compliance and re-issuance of Orders that supported the issuance of a Mandatory Management Order at Caressant Care Woodstock in September 2017. The Director had reasonable and probable grounds to believe that the licensee could not properly manage Caressant Care Woodstock, and the Director has the same belief at Caressant Care Fergus.

Order:	

To Caressant Care Nursing and Retirement Homes Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Pursuant to: *Long Term Care Homes Act,* 2007 S.O. 2007, c.8 s 156 (1). The Director may order a licensee to retain, at the licensee's expense, one or more persons acceptable to the Director to manage or assist in managing the long-term care home.

Order: Caressant Care Nursing and Retirement Homes Limited ("the licensee") is ordered:

(a) to retain one or more persons, at your expense, described in paragraph (c) or (d) of this Order, to manage Caressant Care Fergus located at 450 Queen Street East, Fergus, Ontario ("the long-term care home");

(b) to submit to the Director **within 14 calendar days** of being served with this Order a proposed person(s) described in paragraph (a) to this Order;

(c) the person(s) described in paragraph (a) to this Order must be acceptable to the Director and approved by the Director in writing;

(d) if the licensee does not submit a proposed person(s) described in paragraph (a) to this Order to the Director within the time period specified in paragraph (b) to this Order, the Director will select the person(s) that the licensee must retain to manage the long-term care home;

(e) the person(s) described in paragraph (a) to this Order acceptable to the Director will have

specific qualifications, including:

(i) the experience, skills and expertise required to operate and manage a long-term care (LTC) home in Ontario and to maintain compliance with the LTCHA and Regulation;

(ii) have a good Compliance Record, which for the purpose of this Order means the LTC home for which the person described in paragraph (a) to this Order is a licensee or manager, or to which the person described in paragraph (a) to this Order provides consulting services has a compliance record under the LTCHA that is considered to be Substantially Compliant including:

1. critical incidents that occur are reported as required;
2. complaints are managed effectively in the LTC home;
3. the LTC home develops policies/procedures using evidenced based practice and quality strategies;
4. the LTC home responds to issues identified during inspections; and
5. non-compliance in areas of actual harm or high risk of harm to residents and any other persons identified during inspections are rectified within the time frame required by the inspector.

(iii) demonstrate that they have not, under the laws of any province, territory, state or country, in the three years prior to this order:

1. been declared bankrupt or made a voluntary assignment in bankruptcy;
2. made a proposal under any legislation relating to bankruptcy or insolvency; or
3. have been subject to or instituted any proceedings, arrangement, or compromise with creditors including having had a receiver and/or manager appointed to hold his, her, or its assets.

(f) to submit to the Director a written contract pursuant to section 110 of the LTCHA **within 14 calendar days** of receiving approval of the Director pursuant to paragraph (c) of this Order or the selection of a person(s) pursuant to paragraph (d) of this Order;

(g) to execute the written contract **within 24 hours** of receiving approval of the written contract

from the Director pursuant to section 110 of the *Long-Term Care Homes Act, 2007* and to deliver a copy of that contract once executed to the Director;

(h) to submit to the Director a management plan, prepared in collaboration with the person described in paragraph (a) to this Order, to manage the long-term care home and that specifically addresses strategies to achieve compliance with those areas identified as being in non-compliance **within 30 calendar days** of receiving approval of the Director pursuant to paragraph (c) of this Order or the selection of a person pursuant to paragraph (d) of this Order;

(i) the person approved by the Director pursuant to paragraph (c) to this Order or selected by the Director pursuant to paragraph (d) of this Order, shall begin managing the home in accordance with the written contract described in paragraph (g) to this Order **within 24 hours** of the execution of that written contract;

(j) the management of the home by the person described in paragraph (a) to this Order is effective until advised otherwise by the Director; and

(k) any and all costs associated with complying with this Order are to be paid for by the licensee, including for certainty, but not limited to, all costs associated with retaining the person described in paragraph (a) to this Order.

Grounds:

Caressant Care Nursing and Retirement Homes Limited is licensed to operate a long-term care home known as Caressant Care Fergus located at 450 Queen street east, Fergus, Ontario ("the LTC home").

The licensee has not complied with the following requirements under the *Long-Term Care Homes Act, 2007*, S.O. 2007:

On June 15, 2016, inspectors conducted a Resident Quality Inspection (2016_325568_0015) and issued 23 written notifications, 16 voluntary plans of correction and 3 compliance orders, which included the following non-compliance:

- Regulation, s. 53(4), the inspector found that strategies were not developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

  A compliance order was issued pursuant to section 153(1)(b) ordering the licensee to prepare and submit a plan for achieving compliance with O.Reg 79/10 s. 53(4)(b). The plan must include: What immediate and long term interventions/strategies will be implemented for an identified resident and any other resident exhibiting a similar type of

behaviour to ensure their safety. How these interventions will be tracked and audited. What immediate and long term interventions/strategies will be implemented to prevent further incidents from occurring? What procedures would be implemented for residents with patterns of and escalating behaviours? The procedures should include all possible interventions including access to internal/external supports, triggers and timing for referral to external specialists, access to High Intensity Needs funding for one to one staffing and preferred accommodation.

- Regulation, s. 55, the inspector found that procedures and interventions were not developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

  A compliance order was issued pursuant to section 153(1)(a) ordering the licensee to ensure that resident's exhibiting responsive behaviours are identified and there is a process in place to alert staff of those residents that pose a potential risk to themselves or others. Procedures, strategies and interventions are developed and implemented to minimize the risk of altercations and potentially harmful interactions between and among residents. To ensure that the Behavioural Support team observations, identification of triggers, and suggested strategies/interventions to manage a resident's responsive behaviours are included in the resident's plan of care which is accessible to staff. To ensure that a monitoring process is in place to ensure that staff are aware of what resident's are high risk and whether interventions are being implemented.

- LTCHA, s.76(7)3, Staff who provided direct care to residents did not receive training at times or at intervals provided for in the regulations related to behaviour management. This was issued as a voluntary plan of correction.
- LTCHA, s. 6(4)(a), Staff and others involved in the different aspects of care of the resident did not collaborate with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other. This was issued as a voluntary plan of correction.
- LTCHA, s. 3(1)19, The licensee did not respect a resident's right to have his or her choices respected. This was issued as a voluntary plan of correction.
- LTCHA, s. 24(1), The licensee did not ensure that an incident of staff to resident verbal abuse was immediately reported to the Director. This was issued as voluntary plan of correction.
- LTCHA, s. 23(1)(a)(i)(2), The licensee did not immediately investigate an alleged physical abuse that resulted in harm/potential harm to the resident. The licensee did not inform the Director of the results of an investigation or actions taken with respect to the alleged

abuse. This was issued as voluntary plan of correction.

- LTCHA, s.20(1), The licensee failed to comply with their policy to promote zero tolerance of abuse and neglect of residents. This was issued as voluntary plan of correction.
- LTCHA, s.19(1), The licensee failed to protect residents from abuse. This was issued as a voluntary plan of correction.
- LTCHA, s.15(2)(a), The licensee did not ensure that the home, furnishings and equipment were kept clean and sanitary.

  A compliance order was issued pursuant to section 153(1)(a) ordering the licensee to ensure that the home's housekeeping policies and procedures include schedules for the following items; that these schedules/procedures are implemented; and that there is a process in place for monitoring the cleaning schedules to ensure that the home, furnishings and equipment are kept clean and sanitary: Baseboards in all resident rooms, bathrooms and common areas; Floor stains in resident washrooms and tub rooms; Window screens in resident rooms and common areas; Cleaning/dusting of high level areas such as vents in common areas, resident rooms and washrooms; and skylights; High touch areas such as railings, door frames to resident rooms and washrooms; Washing and replacement of privacy curtains in resident rooms and tub rooms.
- Regulation, s. 97(1)(b), The licensee did not notify a resident's substitute decision-maker within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. This was issued as written notification.
- Regulation, s. 90(1)(b), As part of the organized program of maintenance services, the licensee did not ensure that there were schedules and procedures in place of routine, preventive and remedial maintenance. This was issued as written notification.
- Regulation, s. 87(2)(d), The licensee failed to ensure that procedures were implemented for addressing incidents of lingering offensive odours. This was issued as voluntary plan of correction.
- Regulation, s. 8(1)(b), The licensee failed to ensure their skin and wound care policy was complied with. This was issued as voluntary plan of correction.
- Regulation, s. 73(1)10, The licensee failed to ensure that proper techniques to assist residents with eating, including safe positioning of residents who require assistance was provided. This was issued as voluntary plan of correction.
- Regulation, s. 68(2)(c), The licensee failed to ensure that the nutrition care and hydration programs included implementation of interventions to mitigate and manage the identified risks related to nutrition care. This was issued as voluntary plan of correction.
- Regulation, s. 50(2)(c),(d) The licensee failed to ensure that a resident was repositioned every two hours and that equipment, supplies, devices and positioning aids were readily available at the home as required to relieve pressure for a resident exhibiting altered skin

integrity. This was issued as voluntary plan of correction.

- Regulation, s. 37(1)(a) The licensee failed to ensure that each resident of the home has his or her personal care items labelled. This was issued as voluntary plan of correction.
- Regulation, s. 26(3)18,21 The licensee failed to ensure that a plan of care is based on at a minimum, interdisciplinary assessment of special treatments and interventions and sleep patterns and preferences with respect to the residents. This was issued as voluntary plan of correction.
- Regulation, s. 229(4) The licensee failed to ensure that all staff participated in the implementation of the infection prevention and control program. This was issued as voluntary plan of correction.
- Regulation, s. 15(1)(a) The licensee failed to ensure that where bed rails are used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident. This was issued as voluntary plan of correction.
- Regulation, s. 131 (1) The licensee failed to ensure that all areas where drugs are stored were kept locked at all times when not in use. This was issued as written notification.
- Regulation, s. 129(1)(b) The licensee has failed to ensure that controlled substances were stored in a separate locked area within the locked medication cart. This was issued as voluntary plan of correction.

On October 26, 2016 inspectors conducted a Complaint Inspection (2016_538144_0078) and issued 4 written notifications, 4 voluntary plans of correction , which included the following non-compliance:

- LTCHA, s. 6(7) The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan related to dietary needs. This was issued as a voluntary plan of correction.
- Regulation, s. 8(1)(b) The licensee did not comply with the home's weight policy and a resident was not re-weighed when they experienced a significant weight change. This was issued as a voluntary plan of correction.
- Regulation, s. 231(b) The licensee failed to ensure that a resident's written record was kept up to date at all times. This was issued as voluntary plan of correction.
- Regulation, s 129(1)(a) The licensee failed to ensure that drugs were stored in an area or medication cart, that was used exclusively for drugs and drug-related supplies and that was secured and locked. This was issued as voluntary plan of correction.

On October 26, 2016 inspectors conducted a Critical Incident System Inspection (2016_262523_0039) and issued 6 written notifications and 4 voluntary plan of correction including the following non-compliance:

- LTCHA, s. 6(4)(a), 6(7) The licensee failed to ensure that staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other and that the care set out in the plan of care was provided to the resident as specified in the plan. This was issued as a voluntary plan of correction.
- LTCHA, s.3(1)3, 8 The licensee did not respect a resident's right not to be neglected by the licensee or staff and the licensee did not fully respect and promote the resident's right to afford privacy in treatment and in caring for his or her personal needs. This was issued as voluntary plan of correction.
- Regulation, s. 26(3)15,19 The licensee failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the resident's skin condition, including altered skin integrity and with respect to resident safety risks. This was issued as voluntary plan of correction.
- LTCHA, s 20(1) The licensee failed to ensure the written policy to promote zero tolerance of abuse of residents was complied with respect to resident to resident and staff to resident physical abuse. This was issued as voluntary plan of correction.
- Regulation, s. 91 The licensee failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times. This was issued as written notification.
- Regulation, s.107(4) The licensee failed to ensure that within 10 days of becoming aware of the incident, to make a report in writing to the Director setting out the outcome or current status of the individual or individuals who were involved in the incident. This was issued as written notification.

On October 26, 2016 inspectors conducted a follow-up Inspection (2016_262523_0038) and issued 4 written notifications, 1 Director Referral, 4 compliance orders, 1 voluntary plan of correction including the following non-compliance:

- Regulation, s. 53(4) the inspector found that the licensee did not comply with the compliance order issued on August 4, 2016, in relation to inspection number 2016_325568_0015. The inspector found that a resident exhibited behaviours related to the refusal for the provision of personal care and staff were unsuccessful in identifying the triggers for these behaviours and developing and implementing strategies to respond to these behaviours. The inspector found that a resident exhibited exit seeking behaviours and the licensee did not develop and implement strategies to respond to these behaviours. A compliance order was issued pursuant to section 153(1)(a) ordering the licensee to ensure that a process was developed and implemented for all residents demonstrating responsive behaviours to ensure that strategies have been developed and implemented to respond to the residents responsive behaviours.

- Regulation, s 55 the inspector found that the licensee did not comply with the compliance order issued on August 4, 2016, in relation to inspection number 2016_325568_0015. The inspector found that procedures, strategies and interventions were not developed and implemented to minimize the risk between and among residents. A monitoring process was not implemented to ensure staff were aware of resident's at high risk and whether interventions were implemented. A compliance order was issued pursuant to section 153(1)(a) ordering the licensee to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

- LTCHA, s.15(2)(a) The inspector found that the licensee did not comply with the compliance order issued on June 15, 2016, in relation to inspection number 2016_325568_0015. The inspectors found that the licensee did not ensure that the home, furnishings and equipment were kept clean and sanitary. A Director referral and a compliance order was issued pursuant to section 153(1)(a) ordering the licensee to ensure that there is a process developed and implemented for the scheduled cleaning of the home, furnishings and equipment including window screens, light covers, ceiling tiles, privacy curtains, flooring and baseboards in resident rooms, bathrooms and common areas. The home shall ensure a monitoring process is developed and implemented including the staff responsible for monitoring to ensure that the home, furnishings and equipment are kept clean and sanitary.

- LTCHA, s.15(2)(c) The inspector found that the licensee did not comply with the compliance order issued on August 18, 2015, in relation to inspection number 2015_448155_0020. The inspectors found that the licensee did not ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair. A Director referral and a compliance order was issued pursuant to section 153(1)(a) ordering the licensee to ensure that a process is developed and implemented that identifies which staff are responsible for the monitoring and ensuring the home, furnishings and equipment are in a safe condition and in a good state of repair.

- Regulation, s. 87(2)(d) The licensee failed to ensure that procedures were implemented for addressing incidents of lingering offensive odours. This was issued as voluntary plan of correction.

On October 26, 2016, inspectors conducted a complaint inspection (2016_262523_0040) and issued 2 written notifications, 2 compliance orders including the following non-compliance:

- LTCHA, s. 6(4)(a) The licensee failed to ensure that staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other. A compliance order was issued pursuant to section 153(1)(a)

ordering the licensee to ensure that staff involved in the different aspects of residents care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complemented each other.

- LTCHA, s. 19(1) The licensee failed to ensure that residents were not neglected by the licensee or staff. A compliance order was issued pursuant to section 153(1)(a) ordering the licensee to ensure that residents are not neglected by the licensee or staff and the licensee shall complete a review of the falls prevention program and ensure that residents are assessed post falls and their plan of care is updated accordingly. The licensee shall ensure that the physician is called and informed at the time there is a change in the resident status.

On October 31, 2016, inspectors conducted a complaint inspection (2016_538144_0079) and issued 2 written notifications, 2 voluntary plans of correction including the following non-compliance:

- Regulation, s. 26(3)15 - The licensee failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of the resident's skin condition, including altered skin integrity. This was issued as voluntary plan of correction.

- LTCHA, s. 3(1)1 - The licensee failed to ensure the resident's right to be treated with courtesy and respect and in a way that fully recognized their individuality and dignity. This was issued as voluntary plan of correction.

On March 29, 2017 inspectors conducted a critical incident system inspection (2017_601532_0004) and issued 5 written notifications, 4 voluntary plan of correction including the following non-compliance:

- LTCHA, s. 6(10)(b) The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the residents care needs changed or care set out in the plan was no longer necessary. This was issued as a voluntary plan of correction.
- LTCHA, s. 20(3) The licensee failed to ensure that the policy to promote zero tolerance of abuse and neglect of residents was communicated to all staff, residents and substitute decision-makers. This was issued as a voluntary plan of correction.
- LTCHA, s. 76(2)4 The licensee failed to ensure that staff received training in the area of mandatory reporting under section 24 of the Act of improper or incompetent treatment or care, unlawful conduct, abuse or neglect resulting in harm or potential harm to a resident, prior to performing their responsibilities. This was issued as voluntary plan of correction.
- Regulation, s. 98 The licensee failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. This was issued as

written notification.

- Regulation, s. 221(2) The licensee failed to ensure that all staff who provided direct care to residents, received training relating to abuse recognition and prevention: annually; as determined by the licensee, based on the assessed training needs of the individual staff member. This was issued as a voluntary plan of correction.

On August 24, 2017 inspectors conducted a Follow Up Inspection (2017_508137_0018) and issued 6 written notification, 5 compliance orders, 1 voluntary plan of correction including the following non-compliance:

- Regulation, s. 53(4), the inspector found that the licensee did not comply with the compliance order issued on February 24, 2017, in relation to inspection number 2016_262523_0038. The inspector found that the licensee failed to ensure that a process was developed and implemented for all residents demonstrating responsive behaviours and that strategies were developed and implemented to respond to the resident's responsive behaviours.

  A compliance order was issued pursuant to section 153(1)(a) ordering the licensee to ensure there is a process developed and implemented for all residents demonstrating responsive behaviours and to ensure strategies have been developed and implemented to respond to the residents responsive behaviours. The process shall include staff roles and responsibilities including which staff are responsible for monitoring the implementation of the strategies.

- Regulation, s. 55, the inspector found that the licensee did not comply with the compliance order issued on February 24, 2017, in relation to inspection number 2016_262523_0038. The inspector found that the licensee failed to ensure that, procedures and interventions were developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

  A compliance order was issued pursuant to section 153(1)(a) ordering the licensee to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

- LTCHA, s. 6(4)(a) The inspector found that the licensee did not comply with the compliance order issued on November 3, 2016, in relation to inspection number 2016_262523_0040. The inspector found that the staff and others involved in the different aspects of care of the resident did not collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement

each other. A compliance order was issued pursuant to section 153(1)(a) ordering the licensee to ensure that the staff involved in the residents' care collaborate with each other in the assessment of the residents so that their assessments are integrated, consistent with and complement each other, including post fall assessments. On March 1, 2018, the compliance order was complied.

- LTCHA, s.15(2)(a)(c) - The inspector found that the licensee did not comply with the compliance orders issued on October 26, 2016, in relation to inspection number 2016_262523_0038. The inspectors found that the licensee did not ensure that the home, furnishings and equipment were kept clean and sanitary and were maintained in a safe condition and in a good state of repair.

  A Director Referral and a compliance order were issued pursuant to section 153(1)(a) ordering the licensee to ensure that there is a process developed and implemented for the scheduled cleaning of the home, furnishings and equipment, including window screens, light covers, ceiling tiles, privacy curtains, flooring and baseboards in resident rooms, bathrooms and common areas. The referral and compliance order were also issued to ensure a monitoring process is developed and implemented, including the staff responsible for monitoring, to ensure that the home, furnishings and equipment are kept clean and sanitary. Also requested that a process be developed and implemented that identifies which staff are responsible to ensure and monitor that the home's furnishings and equipment are maintained in a safe condition and in a good state of repair. On March 1, 2018, the compliance order was complied.

- LTCHA, s.19(1) - The inspector found that the licensee did not comply with the compliance orders issued on November 3, 2016, in relation to inspection number 2016_262523_0040. The inspectors found that the licensee did not ensure that residents were not neglected by the licensee or staff.

  A Director Referral and a compliance order was issued pursuant to section 153(1)(a) ordering the licensee to ensure that the residents are not neglected by the licensee or staff. The licensee was ordered to complete a review of the falls prevention program and ensure that residents are assessed post falls and their plan of care is updated accordingly and that the physician is called and informed at the time there is a change in the resident's status. The licensee was ordered to develop and implement a process to ensure there is adequate fall prevention devices to meet the needs of all residents at risk of falls and identify who will be responsible for maintaining these fall prevention devices, to ensure they are in good working order and removed from use when expired. On March 1, 2018, the compliance order was complied.

- Regulation, s.107(3)4 - The licensee failed to ensure that the Director was informed when a resident had an incident that caused an injury for which the resident was taken to a hospital and that resulted in a significant change in the resident's health condition. This

was issued as voluntary plan of correction.

On October 4, 2017, as part of the Director's Referral issued during Follow Up Inspection #2017_508137_0018, the Director considered the scope and severity of the non-compliances, along with the licensee's history of compliance and determined that it was necessary to issues three Director orders.

- LTCHA, s. 15(2)(a)(c) the licensee shall ensure that the home, furnishings and equipment were kept clean and sanitary and were maintained in a safe condition and in a good state of repair.

  A Director Order was issued pursuant to section 153(1)(a) ordering the licensee to bring in a professional cleaning company to complete a deep cleaning of the home's equipment, furnishings, floors and any other surfaces requiring cleaning with a particular focus on areas where personal care of residents is provided. To develop and implement policies, procedures and a schedule to ensure that the home furnishings and equipment are kept clean and sanitary, maintained in a safe condition and a good state of repair with particular attention to infection prevention and control in areas of resident care. To develop and submit a plan to the Director outlining the repairs that need to be completed in the home and a timeline for completion of the repairs. Once the plan has been approved by the Director, to implement the plan in accordance with the timelines identified. Repairs as they relate to residents' car and safety needs and quality of life in the home, include: baseboards in residents' rooms and throughout, door frames, bathroom vanity cupboards, stained flooring, skinks with rusty stoppers impacting proper cleaning and infection prevention and control etc.

- LTCHA, s. 19(1) The licensee shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

  A Director Order was issued pursuant to section 153(1)(a) ordering the licensee to bring in a consultant from an external company with extensive experience in managing or operating LTC homes to conduct a review of the following areas and make recommendations for improvement regarding the following: the falls and responsive behaviour programs, the other required programs as set out in the LTCHA, s.8-16 and O.Reg 79/10, s 48, the equipment available within the home to support the assessed care and safety needs of residents including bed alarms, chair alarms and posey alarms. Upon completion of the review the findings and recommendations will be set out in a report which will be provided by the consultant to both the licensee and the Director under the Act. This review and findings must be finalized no later than November 30, 2017. Within two weeks of receiving the report from the review, the licensee will submit a plan to the Director identifying the recommendations that will be implemented and the timelines for implementation. Upon approval of the plan by the Director, the licensee will implement the actions identified.

- LTCHA, s. 101(3)(4) It is the condition of every license that the licensee shall comply with

this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every order made or agreement entered into under this Act and those Acts. Every licensee shall comply with the conditions to which the license is subject.

A Director Order was issued pursuant to section 153(1)(a) ordering the licensee to submit a plan to provide coaching and mentoring support to the Administrator and Director of Care at Caressant Care Fergus relating to their respective roles and responsibilities specifically with respect to ensuring and sustaining compliance with requirement under the LTCHA. Given the repeated non-compliance with Orders and Director's Referrals at this home, the lack of understanding exhibited to ministry inspectors with respect to requirements under the LTCHA and the actions needed to address the non-compliance, it is necessary to ensure the leadership team at the home is well positioned to ensure the care and safety of resident's in the home. This coaching and mentoring will support the Administrator and Director of Care to achieve compliance with the specific areas of non-compliance and ensure they have the knowledge and skills to sustain that compliance. The plan will include the areas to be covered in the coaching and mentoring, timelines for the coaching and mentoring and a report at the end of the mentoring period confirming the areas identified have been covered. The areas covered are to include at a minimum, a detailed overview of the LTCHA and Regulation 79/10 with a particular focus on the current outstanding non-compliance, the requirements of outstanding Inspector and Director's Orders and areas of non-compliance identified in recent inspections.

On January 8, 2018, inspectors conducted a Resident Quality inspection (2018_448155_0001) and issued 15 written notifications, 2 Director referrals, 5 compliance orders, 8 voluntary plan of correction including the following non-compliance:

- Regulation s.53(4) - The inspector found that the licensee did not comply with the compliance order issued on September 13, 2017, in relation to inspection number 2017_508137_0018. The inspector found that the licensee did not ensure that two identified residents had interventions developed and implemented to manage the behaviours and there were no procedures or interventions developed and implemented to assist residents/staff who were at risk of harm or were harmed as a result of the resident's responsive behaviours. Risk management reports were not completed for the identified incidents. Despite one resident exhibiting responsive behaviours for almost a year, a Behavioural Support Ontario (BSO) referral was not made until inspectors were in the home.

  A Directors Referral and compliance order was issued pursuant to section 153(1)(a) ordering the licensee to ensure that there is a process developed and implemented for all other residents demonstrating responsive behaviours to ensure strategies have been developed and implemented to respond to the residents responsive behaviours. The process shall include staff roles and responsibilities including which staff are responsible

for monitoring the implementation of the strategies. The compliance order remains outstanding.

- Regulation, s 55 - The inspector found that the licensee did not comply with the compliance order issued on September 13, 2017, in relation to inspection number 2017_508137_0018. The inspector found that the home's responsive behaviour policy had not yet been implemented and procedures and interventions had not been developed and implemented to assist residents and staff who were at risk of harm or who were harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

  A compliance order was issued pursuant to section 153(1)(a) ordering the licensee to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents. The compliance order remains outstanding.

- LTCHA, s. 6(1)(c) The licensee failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to residents. A compliance order was issued pursuant to section 153(1)(a) ordering the licensee to ensure that the licensee is compliant with s. 6. (1)(c) of the LTCHA. Specifically the licensee must: ensure that the written plan of care for a resident provides clear direction related to specific care; if refusing care the interventions that are to be utilized to ensure resident receives care; any other information pertinent to the care of the resident. To ensure that the written plan of care for a resident included the specific type of devices used for fall prevention and any other information pertinent to the care of the resident. To ensure that the written plan of care for all other residents sets out clear directions to staff and others who provide direct care to the residents. The compliance order remains outstanding.

- Regulation, s. 101 (1) - The licensee failed to ensure that a written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is 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 commence immediately. A compliance order was issued pursuant to section 153(1)(a) ordering the licensee to ensure that the licensee complies with O. Reg. 79/10, s.101. (1). Specifically the licensee must 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. 2. For those

complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. 3. A response shall be made to the person who made the complaint, indicating: i) what the licensee has done to resolve the complaint, or ii) that the licensee believes the complaint to be unfounded and the reasons for the belief. The compliance order remains outstanding.

- Regulation, s. 213(4) - The licensee failed to ensure that everyone hired as a Director of Nursing and Personal Care after the coming into force of this section; had at least one year of experience working as a registered nurse in the long-term care sector; had at least three years of experience working as a registered nurse in a managerial or supervisory capacity in a health care setting; and had demonstrated leadership and communication skills. An immediate compliance order was issued pursuant to section 153(1)(a) ordering the licensee to be compliant with O.Reg. 79/10, s. 213. (4)(a)(b)(c). Specifically, the licensee shall ensure that the long-term care home has an individual employee that is working in the home as the Director of Nursing and Personal Care that has the following: Has at least one year of experience working as a registered nurse in the long-term care sector; Has at least three years of experience working as a registered nurse in a managerial or supervisory capacity in a health care setting; and has demonstrated leadership and communication skills. The licensee must provide the Director written strategies to ensure Director of Nursing and Personal Care coverage until such time an individual is permanently hired in that position, including the name and qualifications of the individual employee that is working in the home as the Director of Nursing and Personal Care at this time. The compliance order remains outstanding.

- LTCHA, s. 3(1)4,7 - The licensee failed to ensure that every resident had the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs and that every resident had the right to be told who is responsible for and who was providing the resident's direct care. This was issued as voluntary plan of correction.

- LTCHA, s. 20(1) - The licensee failed to ensure that there was a written policy that promotes zero tolerance of abuse and neglect of residents and that it was complied with. This was issued as voluntary plan of correction.

- LTCHA, s. 23(1)(a)ii - The licensee failed to ensure that every alleged, suspected or witnessed incident of neglect of a resident by the license or staff, that the licensee knows of, or that is reported to the licensee was immediately investigated. This was issued as voluntary plan of correction.

- LTCHA, s. 24(1)2 The licensee failed to ensure that a person who had reasonable grounds to suspect that financial abuse of a resident by anyone had occurred or may occur shall

immediately report the suspicion and the information upon which it is based to the Director. This was issued as voluntary plan of correction.

- LTCHA, s. 60(2) - The licensee has failed to respond in writing within 10 days of receiving Family Council advice related to concerns or recommendations. This was issued as voluntary plan of correction.

- Regulation, s. 51 (2)(g) - The licensee failed to ensure that residents who require continence care products have sufficient changes to remain clean, dry and comfortable. This was issued as voluntary plan of correction.

- Regulation, s. 129(1)(a)(iv) - The licensee failed to ensure that drugs were stored in an area or a medication cart that complied with manufacturer's instructions for the storage of the drugs. This was issued as voluntary plan of correction.

- Regulation, s. 131(2)4,5,7 - The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber. The licensee failed to ensure that a member of the registered nursing staff permit a staff member, who was not otherwise permitted to administer a drug to a resident, to administer a topical only: if the staff member was trained by a member of the registered nursing staff in the administration of the topical; the member of the registered nursing staff who was permitting the administration was satisfied that the staff member can safely administer the topical; and the staff member who administered the topical does so under the supervision of the member of the registered nursing staff. The licensee failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. The licensee has failed to ensure that no resident who was permitted to administer a drug to himself or herself keeps the drug on his or her person or in his or her room except, as authorized by a physician, registered nurse in the extended class or other prescriber who attends the resident. This was issued as voluntary plan of correction.

- Regulation, s. 107(4) 2. ii - The licensee failed to ensure that where a licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident: 2. A description of the individuals involved in the incident including, ii. names of any staff members or other persons who were present at or discovered the incident. This was issued as written notification.

- Regulation, s. 124 - The licensee failed to ensure that drugs were obtained for use in the home, except drugs obtained for any emergency drug supply, storage were obtained based on resident usage, and that no more than a three-month supply was kept in the

home at any time. This was issued as written notification.

Meetings between the Ministry and the Licensee

On October 2, 2017, a teleconference with the Licensee, Director, a Senior Manager, members of the London and Central West Service Area Office, and Waterloo Wellington Local Health Integration Network (LHIN) was held to discuss the licensee's outstanding compliance orders with LTCHA s. 15 (2); s 19; O.Reg, 79/10 s. 53 (4); s. 55 and the multiple non-compliance findings and lack of program development and accountability to address the non-compliance. The licensee was told by the Director that the Ministry was issuing a suspension of admissions that would be effective as of October 3, 2017. The licensee was advised by the Director that three Director's Orders would be issued on October 4, 2017.

On December 22, 2017, a teleconference with the Licensee, Director, a Senior Manager and members of the London and Central West Service Area Office was held to discuss the final plan that was submitted by the licensee that identified the timelines for implementation of their consultant's recommendations. At this time, the Director requested the licensee to re-submit the plan with additional details to capture the recommendations outlined in the Consultant's Review Report, time frames for implementing the changes and to submit their plan to the Director by January 5, 2018. The Director advised the licensee that the compliance date for Director Order #002 would be extended to March 31, 2018.

Management Instability

During the Resident Quality Inspection on January 8, 2018, the Administrator reported to inspector #155 that the Director of Nursing (DON) resigned with an effective date of February 9, 2018. However, on February 8, 2018 the Administrator reported to the inspector that the DON did not return to the home after January 29, 2018. The inspector told the home to submit a plan detailing DON coverage. On February 12, 2018, a plan was received and the inspector called the home asking the home to explain how their plan met the LTCHA and Regulation. On February 14, 2018, the inspector received an e-mail from the Administrator providing the plan with an explanation, however, it did not meet the requirements as set out in the Regulation.

An immediate compliance order was issued on February 23, 2018 and on February 26, 2018, the home's plan showed that the RAI Co-ordinator would provide coverage as Acting Director of Nursing. On March 2, 2018, the Administrator told inspector #155 that the Acting DON resigned on March 2, 2018, effective immediately. On March 2, 2018 the Regional Manager told inspector #155 that the Resident Care Co-ordinator was no longer employed at the home. The home was without a permanent DON from January 31, 2018 until March 12, 2018 when a new DON started at the home.

The Office Manager position was vacant from November 2017 to February 2018. A new office manager was hired and started at the home in February 2018.

The Administrator has only been in the position at the home since March 2017.

The combination of these vacancies represent the management instability at the home and demonstrates the inability for the senior leadership in the home to demonstrate the experience, skills and expertise to effectively understand the compliance issues and manage the home in accordance with the requirements under the LTCHA and the Regulations.

Based on the licensee's repeated and ongoing failure to ensure the LTC home complies with the LTCHA and the Regulation, the instability of the long-term care home's management team, the licensee's failure to comply with inspector and Director's Orders since 2016, I have reasonable grounds to believe that the licensee cannot properly manage the LTC home.

This order must be complied with by:	The dates as outlined and specified in the Order.

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to appeal this Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the *Long-Term Care Homes Act, 2007*. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with this Order, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

and the

Director
c/o Appeals Clerk
Long-Term Care Inspections Branch
1075 Bay St., 11th Floor, Suite 1100
Toronto ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

Issued on this 19th day of March, 2018	
Signature of Director:	
Name of Director:	Karen Simpson