Ontario

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 prévue 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
Jun 7, 2019	2019_755728_0010	019558-18, 001926-19, 003137-19, 004735-19, 004736-19, 005791-19, 007130-19, 007865-19	Follow up

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

MARIA MCGILL (728), KIYOMI KORNETSKY (743)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): May 1-3, 6-9, and 14-15, 2019.

The following intakes were completed in this follow-up inspection:
Log #003137-19 related to improper care;
Log #005791-19 and log #007130-19 related to alleged neglect;
Log #007865-19 related to alleged staff to resident abuse; and,
Log #001926-19 complaint related to improper care.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), Responsive Health Management (RHM) Nurse Consultant (NC), RHM Director of Operations (DO), Resident Care Coordinator (RCC), Resident Assessment Instrument (RAI) Coordinator (RAI-C), Ward Clerk (WC), Administrative Assistant (AA), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and Health Care Aides (HCA).

The inspector(s) reviewed clinical records and plans of care for relevant residents, pertinent policies and procedures, the home's documentation related to relevant investigations and employee files, and recent Resident Council meeting minutes.

Observations were made of residents, staff to resident interaction, supplies in the home, and resident care provision.

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

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

11 WN(s)
7 VPC(s)
4 CO(s)
1 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #001	2019_755728_0002	728
O.Reg 79/10 s. 47.	CO #001	2018_448155_0006	728

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. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's zero tolerance of abuse and neglect policy, last reviewed September 2018, directed staff that all cases of suspected or actual abuse must be reported immediately to the DOC/Executive Director.

A) A critical incident (CI) was submitted to the Ministry of Health and Long-term Care (MOHLTC) on an identified date related to an incident that occurred two days prior. A complaint was also submitted to the MOHLTC related to this incident.

The CI documented that resident #002's family member notified staff that the resident was displaying identified behaviours and was noted to be in a specific state.

The complainant stated that after they had noticed the specified state of the resident they notified staff.

PSW #115 said that when resident #002's family member notified them, they assisted them with the required care. They said that they were not told of the resident's status from the previous shift.

PSW #115 said they would consider the incident to be neglect. They said that because registered staff and the physician in the home were aware of the incident, they felt it was reported.

DOC #109 said that the incident was reported to management the next day. The report did not come from staff in the home. They said that they reported the incident after receiving a complaint alleging abuse and lack of dignity.

DOC #109 said that staff were required to report any instances of suspected neglect immediately and that staff did not report this incident.

The licensee failed to ensure that staff complied with the home's written policy to promote zero tolerance of abuse and neglect of residents on an identified date.

B) A CI was submitted to the MOHLTC related to an incident of alleged abuse or neglect of resident #004. The CI documented that staff member #133 alleged that registered staff member #122 provided improper care when they were notified of a change in health

status. The CI also documented that registered staff #123 said that they would not provide an identified intervention to the resident because of the resident's health status and that they would "say that they did".

The home's investigative documents included a statement from PSW #133 that outlined the incident. The statement had another note attached which stated that they had forgotten to put the letter under DOC #109's door when the incident occurred and provided it to them the next day.

PSW #133 said that they did not report the incident immediately. They said they had written a statement because they were not comfortable reporting to the registered staff on their shift because it was their care that they were concerned about. PSW #133 said they forgot to provide the letter to the DOC immediately after writing it.

DOC #109 said that the expectation was that staff report any incident of alleged abuse, neglect, or improper care immediately and that in this instance, it was not.

The licensee failed to ensure that PSW #133 reported an incident of alleged improper care of resident #004 immediately.

C) A CI was submitted to the MOHLTC related to an incident of alleged staff to resident abuse that occurred during a transfer.

A review of the licensee's investigative notes found that PSW #131 informed the home two days after the incident of alleged staff to resident abuse occurred. They alleged that they witnessed PSW #115 being rough during an identified care task.

PSW #131 said that they did not report the incident of suspected abuse immediately because they were nervous and scared. They recognized that it should have been reported right away.

DOC #109 said that staff receive training about the home's abuse policy, and that PSW #131 should have reported the alleged abuse incident immediately.

The licensee failed to ensure that the home's abuse policy was complied with in relation to immediate reporting of alleged, suspected or witnessed incidents of abuse, neglect or improper care. [s. 20. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

The licensee failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice.

DOC #109 said that PSW's document baths in their Point of Care (POC) system. They said that each resident was required to have two baths per week, and if they refused, staff were supposed to document the refusal in POC and in the nursing notes.

A) Family member #135 and #136 said that resident #007 had not been bathed for two weeks.

Resident #007 was observed to have hair that was greasy.

POC tasks for resident #007 indicated that they had not received a bath during two identified weeks.

The bath schedule indicated that resident #007 was to receive a bath twice weekly on specified days.

DOC #109 said that baths were not completed for resident #007 during two identified weeks because of a glitch with the POC system notifying staff of the task.

B) A prospective review of identified residents at the home was completed. The review identified that resident #011 had not been bathed twice a week.

The resident's plan of care directed staff to provide resident #011 with two baths per week. Staff also had access to the bath binder at the nursing station, which documented that resident #011 required a bath twice weekly on specified dates.

Resident #011 said that they were currently receiving a bath once per week but would prefer two baths per week.

Documentation under the bathing tasks in POC, showed that resident #011 did not receive two baths weekly during an identified week.

Review of the resident's progress notes for the week of April 22-28, 2019, found no documentation about the resident refusing their bath, nor was there documentation in POC.

DOC #109 said that they did not receive two baths weekly.

C) A prospective review of identified residents at the home was completed and it identified that resident #010 had not been bathed twice a week since their admission.

Documentation in the resident's POC, as well as in the bath binder located at the nursing station; instructed staff to provide resident #010 with a bath twice a week on Wednesdays and Saturdays.

Review of the bath task list in POC between a four week period found that resident #010 did not receive a bath during one specified week and received one bath during two specified weeks.

Review of resident #010's progress notes found no documentation that the resident had refused their baths, nor was there any bath refusal documentation in POC.

DOC #109 said that resident #010 had not received two baths per week since they were admitted.

The licensee failed to ensure that resident #007, #010, and #011 were bathed twice weekly. [s. 33. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: 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,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

The licensee failed to ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, were reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

This inspection was completed as a follow-up to CO #002 from inspection 2019_755728_0002 related to O.Reg.79/10, s.50(2)(b)(iv). Specifically, the licensee was to ensure that resident #004 and all other resident's exhibiting altered skin integrity were assessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A) Resident #004 was to receive weekly wound care and assessments for an identified area of altered skin integrity. On a specified date, a weekly Skin and Wound evaluation was initiated; however, the assessment failed to include information about the wound

bed, measurements, exudate, peri wound, wound pain, treatment and progress. RPN #110 failed to outline the wound picture in PCC; a process required to update the wound measurements in the skin and wound evaluation and assessment tab. DOC #109 said that if the wound was not outlined in PCC, then the measurements were stored in the iPod and could not be viewed by staff.

RPN #110 said that on an identified date, they didn't have time to complete the weekly skin and wound assessment of resident #004's area of altered skin integrity in PCC. They also said that the area had healed. However, once the wound measurements were entered the next week (six days later), as a late entry, the measurements indicated that the area of altered skin integrity was not healed. The week after the assessment was missed, the weekly skin and wound assessment in PCC showed that the area of altered skin integrity had increased in size.

The licensee failed to ensure that resident #004, who was exhibiting altered skin integrity, received a weekly skin assessment by a registered nursing staff.

B) Resident #006, who had a documented area of altered skin integrity, was not assessed at least weekly by a registered nursing staff.

DOC #109 and RPN #111 said the skin and wound assessment in PCC titled Skin and Wound Evaluation, should be completed once a week for areas of altered skin integrity.

On an identified date, documentation in the progress notes indicated that resident #006 had a new area of altered skin integrity. RPN #129 completed the Skin and Wound Evaluation in PCC and a picture of the wound was uploaded under the skin and wound tab.

During the inspection, an observation was made of RPN #126 providing wound care to resident #006's identified area of altered skin integrity. The observation noted that the wound was pink in colour with open areas. RPN #126 documented the assessment using the Home's Skin and Wound Evaluation.

On an identified date, RPN #111 completed the Skin and Wound Evaluation assessment of the area of altered skin integrity and uploaded a photo of the wound. The photo showed red open areas. However, measurements of the wound were not documented.

No skin and wound assessments were documented over a three week period. RPN #126

said that the skin and wound assessments were not completed of the resident's area of altered skin integrity for the identified weeks. They said that the assessments had been missed.

The licensee failed to ensure that resident #006's area of altered skin integrity was reassessed at least weekly by a member of the registered staff. [s. 50. (2) (b) (iv)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #4: 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,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

The licensee failed to ensure that each resident who was incontinent received an assessment and that where the condition or circumstances of the resident require, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

DOC #109 said that staff were required to complete the Caressant Care's Continence assessment tool in PointClickCare (PCC) within 7 days of admission.

RCC #118 said the home's clinically appropriate continence assessment tool in PCC was

useful in determining a continence baseline for residents.

A) Resident #007 was admitted to the home on an identified date. Their progress note on admission stated that they were admitted with identified care requirements for incontinence.

There was no continence assessment documented in the resident's plan of care. Their plan of care for toileting and continence stated that they required identified care.

RAI-C #121 said that continence assessments were completed in PCC under the assessments tab. RN #128 said that there was no continence assessment completed for resident #007.

Four weeks after the resident's admission, a continence assessment was completed in PCC for resident #007. The plan of care was also updated documenting that the resident required different care than what was previously documented.

RCC #118 said that resident #007's continence was reviewed and their care plan was updated to reflect this review.

A review of the residents admission MDS, identified that the resident met the MDS criteria for requiring a continence assessment.

DOC #109 said that a continence assessment should have been completed for resident #007 and that it had not been completed.

B) A prospective review was completed on new admissions and it was identified that resident #011, who had an identified level of incontinence, did not receive a continence assessment using the Home's clinically appropriate assessment tool.

Review of the MDS assessment, as well as review of the resident's Bowel and Bladder continence records in POC, found that approximately four weeks after admission, the resident was displaying an identified level of incontinence.

Resident #011's care plan identified that the resident required a specified level of care related to toileting.

A review of the assessments completed during a four week period since their admission,

found that the home did not complete a continence assessment using their clinically appropriate tool, titled Caressant Care Assessment of Resident Continence Status.

DOC #109 said that a continence assessment tool should have been completed for resident #011 and that is was not.

C) A prospective review was completed on new admissions and resident #010, who was incontinent, did not receive a continence assessment using the Home's clinically appropriate assessment tool.

A record review was completed, and documentation in PCC showed that resident #010 was admitted to the home on an identified date.

A review of the resident's bladder and bowel continence records in POC found that during a four week period following their admission, the resident displayed a specified level of incontinence.

Resident #010's initial care plan instructed staff to provide an identified level of care related to incontinence.

Documentation in the resident's progress notes indicated that the resident's substitute decision maker (SDM) expressed concerns about the care related to toileting. RPN #127 documented that they updated the care plan to include further interventions.

Review of the assessments completed in PCC found that the Caressant Care Assessment of Resident Continence Status assessment tool was not completed.

DOC #109 said that the continence assessment tool should have been completed for resident #010 and it was not.

The licensee failed to ensure that resident #007, #010, and #011, received an assessment that included identification of casual factors, patterns, type of incontinence, and potential to restore functions with specific interventions; when they failed to assess the resident using the home's clinically appropriate assessment tool titled Caressant Care Assessment of Resident Continence Status. [s. 51. (2) (a)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

The licensee failed to ensure that every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

A CI documented that resident #002's family member notified staff that the resident was in their bed and required specified care.

The complaint stated that resident #002 was found to be in an identified state that was not considered to be dignified.

PSW #101 and #124 both said that they were working day shift and assisted resident #002 back to bed after lunch. When they checked back on the resident prior to the end of their shift, the resident was still in bed.

PSW #115 said that when resident #002's family member notified them, they saw that resident #002 required care. They said that they were not told from the previous shift of the resident's status.

PSW #115 said that they should not have been left in that manner.

The complaint stated that this incident did not respect resident #002's dignity.

The licensee has failed to ensure that resident #002 was treated with courtesy and respect and in a way that fully respects the resident's dignity. [s. 3. (1) 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 to ensure that every resident is treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

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.

Resident #007's plan of care identified that they had falls prevention interventions in place.

An observation of the resident noted that one of the specified interventions for falls prevention was not in place.

DOC #109 completed an observation of the resident's room and noted that the specified intervention for falls prevention had not been implemented.

The licensee has failed to ensure that falls prevention interventions were provided to resident #007 as specified in their plan of care. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any procedure the procedure was complied with. In accordance with s. 50(2) of Ontario Regulation 79/10, the licensee was required to ensure that each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions. Specifically, staff did not comply with the licensee's procedure related to completing voiding diaries as outlined in their policy titled Bladder and Bowel Management Program, last reviewed November, 2018, which was part of the licensee's continence care and bowel management program.

The home's policy titled Bladder and Bowel Management Program, last reviewed November 2018, directed staff to conduct a 3-day voiding record and a 7-day bowel record upon admission.

It stated that the interdisciplinary team would complete a care plan within 21 days of admission in collaboration with the interdisciplinary team and continue to update and adjust based on RAI/MDS assessments. They would utilize information gathered in the three- day voiding record, seven-day bowel record and Caressant Care's Continence Assessment (if applicable) to create an individualized toileting program for each resident. These interventions would be added to the care plan and POC tasks.

A) Resident #007 was admitted to the home on a specified date. Their bowel and bladder voiding diary was completed for three days. There was no bowel movement documented in the diary for the three days that it was completed.

DOC #109 and RCC #118 said that the voiding diary was to be completed on admission for 7 days. RCC #118 said that the voiding diary was not completed as directed by the home's policy.

B) A prospective review of newly admitted residents was completed and resident #011 did not have a three-day void record, or a seven- day bowel record completed.

Resident #011 was admitted to the home on an identified date.

DOC #109 said that the voiding diary was a required continence assessment for all new admissions and RCC #118 said that the voiding diary provided data to support interventions.

After review of the resident's chart and files, RCC #118 said they could not locate resident #011's admission three-day void record and seven-day bowel record.

The licensee failed to ensure that the procedure related to completing voiding diaries as outlined in their bladder and bowel program policy was complied with. Specifically, the licensee failed to ensure that resident #007 and resident #011's bladder and bowel voiding diary was completed. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the voiding diaries are completed as directed by the home's policy, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

The licensee failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

Ontario Regulation 79/10, s. 104 (2) states that the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. If not everything required in the report can be provided within 10 days, the licensee shall make a preliminary report to the Director within 10 days and provide a final report to the Director within a period of time specified by the Director.

A) A critical incident was submitted to the MOHLTC related to an incident of alleged neglect of a resident.

The critical incident was amended the same day the original CI was submitted.

The critical incident stated that an allegation of neglect was made and that an investigation was initiated. It stated that immediate actions included staff education and monitoring of the resident.

The critical incident did not document the results of the investigation.

The home's documentation included interviews with staff members involved that were completed.

An amendment providing the results of the investigation was filed after the inspectors were in the home.

B) A CI was submitted to the MOHLTC related to an incident of alleged neglect.

The CI documented an alleged incident of improper care. It documented that the CI would be updated following an investigation.

The home's documentation related to the incident included interviews completed with relevant staff and a letter of discipline.

The CI was amended once inspectors commenced their inspection of the critical incident.

DOC #109 said that the CI's were not updated to include the results of the investigation because Clinical Consultant #103 had planned to review their suggested amendments prior to submitting.

The licensee failed to ensure that the results of the investigation related to improper care/neglect of resident #002 and #004 were reported to the Director. [s. 23. (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 to ensure that the results of the abuse or neglect investigation are reported to the Director, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (1) Every licensee of a long-term care home shall ensure that a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home. O. Reg. 79/10, s. 24 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that at 24-hour admission care plan was developed for each resident and communicated to direct staff within 24 hours of the resident's admission to the home.

A prospective review was completed for new resident's and inspection of resident #011's file found that the home did not complete a 24-hour admission care plan for the resident.

A record review in point click care (PCC) found that resident #011 was admitted to the home on an identified date and review of the assessments completed post admission found that the home's 24-hour admission care plan, titled CC 24h Admit CP Trigger Identifier was not completed for the first month following admission.

According the home's CC24h Admit CP Trigger Identifier assessment tool, the resident was to be assessed for activities of daily living (ADL) that included their capabilities related to bed mobility, transfers, ambulation, locomotion on and off the unit, dressing, eating, toilet use, personal hygiene and bathing. Out of all these ADL subsections, the home documented the residents eating and dietary needs in the care plan within twenty four hours. However, the remaining ADL activities were not documented in the care plan until five to 22 days later.

The home's 24-hour care plan also assessed the resident's specific continence level, pain, comfort and safety. Urinary continence, safety and resident specifics were completed within 24 hours; bowel incontinence was not documented on the care plan until 23 days later and pain was not documented on the care plan until 15 days later.

When asked if the home had completed the 24-hour admission care plan titled CC 24h Admit CP Trigger Identifier, DOC #109 said it was not there. When asked how staff would know what care to provide a new resident without this completed assessment, DOC #109 said they would not know what care to provide. DOC #109 confirmed the the resident's care plan was not updated to include the care requirements of the resident.

The licensee failed to ensure that a 24-hour admission care plan was developed for resident #011 and was communicated to direct care staff within 24 hours of the resident's admission; when they failed to complete the home's CC24h Admit CP Trigger Identifier assessment tool. [s. 24. (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 to ensure that at 24-hour admission care plan is developed for each resident and communicated to direct staff within 24 hours of the resident's admission to the home, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (3) It is a condition of every licence 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 directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Findings/Faits saillants :

1. The licensee has failed to comply with the following requirement of the LTCHA: it was a condition of every license that the licensee shall comply with every order made under this Act.

On December 28, 2018, the following compliance order (CO#001) from inspection number 2018_448155_0006 was issued under s. 47 of the Ontario Regulation 79/10:

The licensee must be compliant with O.Reg. 79/10, s. 47.(1), (2), and (3)(c).

Specifically the licensee must:

a) Ensure that personal support worker #125, #138, #141, #144, #147, #164 and all personal support workers hired after January 1, 2016 have successfully completed a personal support worker program that meets the requirements in subsection (2).
b) Verify that personal support worker #125, #138, #141, #144, #147, #164 and all personal support workers hired after January 1, 2016 have completed a personal support

worker program that is a minimum of 600 hours in duration, counting both class time and practical experience time and keep records supporting the completion of the hours in the employee's file.
c) Ensure that personal support worker #125, #138, #141, #144, #147, #164 and all personal support workers hired after January 1, 2016 have provided the licensee with proof of graduation issued by the education provider.
d) Have documentation in the employee file for PSW #150 that verifies that they are currently enrolled in an educational program for registered nurses or registered practical nurses and that in the opinion of the Director of Nursing and Personal Care that the employee has adequate skills and knowledge to perform the duties of a personal support worker.
e) Ensure that if hiring a person who is enrolled in an educational program for registered nurses or registered practical nurses as a personal support worker they must have documentation in the employee file at the time of hire that the person is enrolled in an education program for registered nurses or registered practical nurses and that in the opinion of the Director of Nursing and Personal Care that the employee has adequate skills and knowledge to perform the duties of a personal support worker.

The compliance date was March 31, 2019.

The licensee completed step(s) a, c, d, and e in CO#001.

The licensee failed to complete step(s) b.

A) PSW #105 was hired on an identified date. Their employee file included a certificate from the National Association of Career Colleges Canada that indicated that they had passed the final examination for Personal Support Worker. It also included a diploma and certificate from CDI college. Neither the diploma or transcript indicated the hours that PSW #005 completed for class or practical experience.

ED #100 said that the employee file did not contain the hours completed as part of PSW #105's PSW program.

An e-mail provided from the home that was sent during the inspection indicated that the home had contacted the college and confirmed that PSW #105 had completed the required hours.

The licensee failed to ensure that PSW #005's employee file contained records

supporting the completion of the required minimum of 600 hours in duration, counting both class and practical experience time. [s. 101. (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 to ensure that parts b and e of CO #001 from Inspection 2018_448155_0006 is complied, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
2. An unexpected or sudden death, including a death resulting from an accident or suicide. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

The licensee failed to immediately inform the Director of an unexpected or sudden death.

A complaint was received by the Ministry of Health and Long Term Care (MOHLTC) regarding concerns around the care and assessments provided by staff prior to resident #001's death.

A record review was conducted and documentation in the progress notes in Point Click Care (PCC) indicated that on an identified date staff responded to a specified incident involving the resident.

Documentation in the progress notes indicated that following the specified incident, the resident was not noted to be injured. Vital signs were identified. The resident's mental status was documented.

Less than two hours after the incident the resident was found unresponsive. Documentation in the progress notes indicated that resident #001 was assessed and noted to be absent of vital signs. The coroner was notified and the immediate cause of death was specified to be unrelated to the incident.

DOC #109 said that resident #001 had identified co-morbidities that indicated a decline in health. However, they were not identified as palliative. They said that the family was not expecting the resident to pass away during the identified time.

The licensee failed to ensure that the Director was immediately informed after the sudden death of resident #001; after the resident passed away less than two hours after an incident occurred. [s. 107. (1) 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 to ensure that the Director is immediately informed of an unexpected or sudden death, to be implemented voluntarily.

Issued on this 2nd day of July, 2019

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

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

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MARIA MCGILL (728), KIYOMI KORNETSKY (743)
Inspection No. / No de l'inspection :	2019_755728_0010
Log No. / No de registre :	019558-18, 001926-19, 003137-19, 004735-19, 004736-19, 005791-19, 007130-19, 007865-19
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jun 7, 2019
Licensee / Titulaire de permis :	Caressant-Care Nursing and Retirement Homes Limited 264 Norwich Avenue, WOODSTOCK, ON, N4S-3V9
LTC Home / Foyer de SLD :	Caressant Care Fergus Nursing Home 450 Queen Street East, FERGUS, ON, N1M-2Y7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Penny Silva

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:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Order / Ordre :

The licensee must be compliant with s. 20 (1) of the LTCHA.

Specifically, the licensee must:
a) comply with the home's zero tolerance of abuse and neglect policy and related procedures for reporting incidents of alleged, suspected, or witnessed abuse or neglect.
b) ensure that all staff are aware of and follow the reporting process as outlined in their policy and have documentation of the completed education that is kept in the home.
c) ensure that all staff are aware of roles/responsibilities of who to report to if management are absent and staff are unable to report to the charge nurse directly.

Grounds / Motifs :

1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's zero tolerance of abuse and neglect policy, last reviewed September 2018, directed staff that all cases of suspected or actual abuse must be reported immediately to the DOC/Executive Director.

A) A critical incident (CI) was submitted to the Ministry of Health and Long-term Care (MOHLTC) on an identified date related to an incident that occurred two days prior. A complaint was also submitted to the MOHLTC related to this incident.

The CI documented that resident #002's family member notified staff that the resident was displaying identified behaviours and was noted to be in a specific state.

The complainant stated that after they had noticed the specified state of the resident they notified staff.

PSW #115 said that when resident #002's family member notified them, they assisted them with the required care. They said that they were not told of the resident's status from the previous shift.

PSW #115 said they would consider the incident to be neglect. They said that because registered staff and the physician in the home were aware of the incident, they felt it was reported.

DOC #109 said that the incident was reported to management the next day. The report did not come from staff in the home. They said that they reported the incident after receiving a complaint alleging abuse and lack of dignity.

DOC #109 said that staff were required to report any instances of suspected neglect immediately and that staff did not report this incident.

The licensee failed to ensure that staff complied with the home's written policy to promote zero tolerance of abuse and neglect of residents on an identified date.

B) A CI was submitted to the MOHLTC related to an incident of alleged abuse or neglect of resident #004. The CI documented that staff member #133 alleged that registered staff member #122 provided improper care when they were notified of a change in health status. The CI also documented that registered staff #123 said that they would not provide an identified intervention to the resident because of the resident's health status and that they would "say that they did".

The home's investigative documents included a statement from PSW #133 that outlined the incident. The statement had another note attached which stated that they had forgotten to put the letter under DOC #109's door when the incident

occurred and provided it to them the next day.

PSW #133 said that they did not report the incident immediately. They said they had written a statement because they were not comfortable reporting to the registered staff on their shift because it was their care that they were concerned about. PSW #133 said they forgot to provide the letter to the DOC immediately after writing it.

DOC #109 said that the expectation was that staff report any incident of alleged abuse, neglect, or improper care immediately and that in this instance, it was not.

The licensee failed to ensure that PSW #133 reported an incident of alleged improper care of resident #004 immediately.

C) A CI was submitted to the MOHLTC related to an incident of alleged staff to resident abuse that occurred during a transfer.

A review of the licensee's investigative notes found that PSW #131 informed the home two days after the incident of alleged staff to resident abuse occurred. They alleged that they witnessed PSW #115 being rough during an identified care task.

PSW #131 said that they did not report the incident of suspected abuse immediately because they were nervous and scared. They recognized that it should have been reported right away.

DOC #109 said that staff receive training about the home's abuse policy, and that PSW #131 should have reported the alleged abuse incident immediately.

The licensee failed to ensure that the home's abuse policy was complied with in relation to immediate reporting of alleged, suspected or witnessed incidents of abuse, neglect or improper care.

The severity of this issue was determined to be a level 2 as there was minimal risk of harm. The scope of the issue was a level 3 as it related to three of the three incidents reviewed. The home had a level 3 compliance history as they

had ongoing non-compliance with this section of the LTCHA, that included:
- voluntary plan of correction (VPC) issued March 1, 2018 (2018_448155_0001);
- VPC issued February 23, 2017 (2016_262523_0039);
- VPC issued August 4, 2016 (2016_325568_0015).
(728)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 03, 2019

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Order / Ordre :

The licensee must be compliant with s. 33 (1) of O. Reg 79/10.

Specifically, the licensee must:
a) ensure residents #007, #010, and #011 and any other resident, are provided a minimum of twice weekly bathing, by a method of their choice, unless contraindicated by a medical condition.
b) ensure there is a process of tracking, monitoring, and auditing bathing for residents #007, #010, #011, and any other resident.

Grounds / Motifs :

1. The licensee failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice.

DOC #109 said that PSW's document baths in their Point of Care (POC) system. They said that each resident was required to have two baths per week, and if they refused, staff were supposed to document the refusal in POC and in the nursing notes.

A) Family member #135 and #136 said that resident #007 had not been bathed for two weeks.

Resident #007 was observed to have hair that was greasy.

POC tasks for resident #007 indicated that they had not received a bath during two identified weeks.

The bath schedule indicated that resident #007 was to receive a bath twice weekly on specified days.

DOC #109 said that baths were not completed for resident #007 during two identified weeks because of a glitch with the POC system notifying staff of the task.

B) A prospective review of identified residents at the home was completed. The review identified that resident #011 had not been bathed twice a week.

The resident's plan of care directed staff to provide resident #011 with two baths per week. Staff also had access to the bath binder at the nursing station, which documented that resident #011 required a bath twice weekly on specified dates.

Resident #011 said that they were currently receiving a bath once per week but would prefer two baths per week.

Documentation under the bathing tasks in POC, showed that resident #011 did not receive two baths weekly during an identified week.

Review of the resident's progress notes for the week of April 22-28, 2019, found no documentation about the resident refusing their bath, nor was there documentation in POC.

DOC #109 said that they did not receive two baths weekly.

C) A prospective review of identified residents at the home was completed and it identified that resident #010 had not been bathed twice a week since their admission.

Documentation in the resident's POC, as well as in the bath binder located at the nursing station; instructed staff to provide resident #010 with a bath twice a week on Wednesdays and Saturdays.

Review of the bath task list in POC between a four week period found that resident #010 did not receive a bath during one specified week and received one

bath during two specified weeks.

Review of resident #010's progress notes found no documentation that the resident had refused their baths, nor was there any bath refusal documentation in POC.

DOC #109 said that resident #010 had not received two baths per week since they were admitted.

The licensee failed to ensure that resident #007, #010, and #011 were bathed twice weekly.

The severity of this issue was determined to be a level 2 as there was minimal harm to the residents. The scope of the issue was a level 3 as it related to three of three residents reviewed. The home had a level 3 compliance history as they had ongoing non-compliance that included:
- Voluntary Plan of Correction (VPC) issued December 18, 2019 (2018_508137_0027).
(728)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 19, 2019

Order # / Ordre no : 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2019_755728_0002, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(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

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee must be compliant with s.50 (2)(b)(iv) of O.Reg 79/10.

Specifically, the licensee must:
a) Ensure that resident #004, #006, and all other resident's exhibiting altered skin integrity are assessed at least weekly by a member of the registered nursing staff, if clinically indicated.
b) Develop and fully implement an auditing process to ensure that weekly wound assessments are completed in their entirety. The audit should include the results and actions taken. Documentation of the audit should be kept in the home.

Grounds / Motifs :

1. The licensee failed to ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, were reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The licensee has failed to comply with compliance order #002 from inspection 2019_755728_0002, issued on February 5, 2019 with a compliance date of April 4, 2019.

The licensee failed to ensure that residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, were reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

This inspection was completed as a follow-up to CO #002 from inspection 2019_755728_0002 related to O.Reg.79/10, s.50(2)(b)(iv). Specifically, the licensee was to ensure that resident #004 and all other resident's exhibiting altered skin integrity were assessed at least weekly by a member of the registered nursing staff, if clinically indicated.

A) Resident #004 was to receive weekly wound care and assessments for an identified area of altered skin integrity. On a specified date, a weekly Skin and Wound evaluation was initiated; however, the assessment failed to include information about the wound bed, measurements, exudate, peri wound, wound pain, treatment and progress. RPN #110 failed to outline the wound picture in

PCC; a process required to update the wound measurements in the skin and wound evaluation and assessment tab. DOC #109 said that if the wound was not outlined in PCC, then the measurements were stored in the iPod and could not be viewed by staff.

RPN #110 said that on an identified date, they didn't have time to complete the weekly skin and wound assessment of resident #004's area of altered skin integrity in PCC. They also said that the area had healed. However, once the wound measurements were entered the next week (six days later), as a late entry, the measurements indicated that the area of altered skin integrity was not healed. The week after the assessment was missed, the weekly skin and wound assessment in PCC showed that the area of altered skin integrity had increased in size.

The licensee failed to ensure that resident #004, who was exhibiting altered skin integrity, received a weekly skin assessment by a registered nursing staff.

B) Resident #006, who had a documented area of altered skin integrity, was not assessed at least weekly by a registered nursing staff.

DOC #109 and RPN #111 said the skin and wound assessment in PCC titled Skin and Wound Evaluation, should be completed once a week for areas of altered skin integrity.

On an identified date, documentation in the progress notes indicated that resident #006 had a new area of altered skin integrity. RPN #129 completed the Skin and Wound Evaluation in PCC and a picture of the wound was uploaded under the skin and wound tab.

During the inspection, an observation was made of RPN #126 providing wound care to resident #006's identified area of altered skin integrity. The observation noted that the wound was pink in colour with open areas. RPN #126 documented the assessment using the Home's Skin and Wound Evaluation.

On an identified date, RPN #111 completed the Skin and Wound Evaluation assessment of the area of altered skin integrity and uploaded a photo of the wound. The photo showed red open areas. However, measurements of the

wound were not documented.

No skin and wound assessments were documented over a three week period. RPN #126 said that the skin and wound assessments were not completed of the resident's area of altered skin integrity for the identified weeks. They said that the assessments had been missed.

The licensee failed to ensure that resident #006's area of altered skin integrity was reassessed at least weekly by a member of the registered staff.

The severity of this issue was determined to be a level 2 as there was minimal harm to the residents. The scope of the issue was a level 2 as it related to 2 out of the 3 of the residents reviewed. The home had a level 5 history as they had on-going non-compliance with this section of O.Reg 79/10 that included:
- Compliance order (CO) issued February 5, 2019 (2019_755728_0002);
- CO issued November 20, 2019 (2018_773155_0012). (743)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 08, 2019

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # /
Ordre no : 004

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 51. (2) Every licensee of a long-term care home shall ensure that,

(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Order / Ordre :

The licensee must be compliant with s. 51 (2) of the O.Reg 79/10.

Specifically, the licensee must:
a) Ensure residents #007, #010, and #011, and any other newly admitted residents who are incontinent receive an assessment that includes identification of causal factors, patterns, type of incontinence, and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate instrument that is specifically designed for assessment of incontinence.

Grounds / Motifs :

1. The licensee failed to ensure that each resident who was incontinent received an assessment and that where the condition or circumstances of the resident require, an assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

DOC #109 said that staff were required to complete the Caressant Care's Continence assessment tool in PointClickCare (PCC) within 7 days of admission.

RCC #118 said the home's clinically appropriate continence assessment tool in PCC was useful in determining a continence baseline for residents.

A) Resident #007 was admitted to the home on an identified date. Their progress note on admission stated that they were admitted with identified care requirements for incontinence.

There was no continence assessment documented in the resident's plan of care. Their plan of care for toileting and continence stated that they required identified care.

RAI-C #121 said that continence assessments were completed in PCC under the assessments tab. RN #128 said that there was no continence assessment completed for resident #007.

Four weeks after the resident's admission, a continence assessment was

completed in PCC for resident #007. The plan of care was also updated documenting that the resident required different care than what was previously documented.

RCC #118 said that resident #007's continence was reviewed and their care plan was updated to reflect this review.

A review of the residents admission MDS, identified that the resident met the MDS criteria for requiring a continence assessment.

DOC #109 said that a continence assessment should have been completed for resident #007 and that it had not been completed.

B) A prospective review was completed on new admissions and it was identified that resident #011, who had an identified level of incontinence, did not receive a continence assessment using the Home's clinically appropriate assessment tool.

Review of the MDS assessment, as well as review of the resident's Bowel and Bladder continence records in POC, found that approximately four weeks after admission, the resident was displaying an identified level of incontinence.

Resident #011's care plan identified that the resident required a specified level of care related to toileting.

A review of the assessments completed during a four week period since their admission, found that the home did not complete a continence assessment using their clinically appropriate tool, titled Caressant Care Assessment of Resident Continence Status.

DOC #109 said that a continence assessment tool should have been completed for resident #011 and that is was not.

C) A prospective review was completed on new admissions and resident #010, who was incontinent, did not receive a continence assessment using the Home's clinically appropriate assessment tool.

A record review was completed, and documentation in PCC showed that resident #010 was admitted to the home on an identified date.

A review of the resident's bladder and bowel continence records in POC found that during a four week period following their admission, the resident displayed a specified level of incontinence.

Resident #010's initial care plan instructed staff to provide an identified level of care related to incontinence.

Documentation in the resident's progress notes indicated that the resident's substitute decision maker (SDM) expressed concerns about the care related to toileting. RPN #127 documented that they updated the care plan to include further interventions.

Review of the assessments completed in PCC found that the Caressant Care Assessment of Resident Continence Status assessment tool was not completed.

DOC #109 said that the continence assessment tool should have been completed for resident #010 and it was not.

The licensee failed to ensure that resident #007, #010, and #011, received an assessment that included identification of casual factors, patterns, type of incontinence, and potential to restore functions with specific interventions; when they failed to assess the resident using the home's clinically appropriate assessment tool titled Caressant Care Assessment of Resident Continence Status.

The severity of this issue was determined to be a level 2 as there was minimal harm to the residents. The scope of the issue was a level 3 as it related to three of three residents reviewed. The home had a level 2 compliance history as they had previous non-compliance related to a different subsection. (728)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 19, 2019

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
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.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 7th day of June, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Maria McGill

Service Area Office /
Bureau régional de services : Central West Service Area Office