**Ministry of Long-Term Care**
Long-Term Care Operations Division
Long-Term Care Inspections Branch

**Central West Service Area Office**
609 Kumpf Drive, Suite 105
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Telephone: 1-888-432-7901
Central.West.sao@ontario.ca

**Original Public Report**

**Report Issue Date** August 26, 2022
**Inspection Number** 2022_1114_0001
**Inspection Type**
☐ Critical Incident System ☐ Complaint ☐ Follow-Up ☐ Director Order Follow-up
☒ Proactive Inspection ☐ SAO Initiated ☐ Post-occupancy
☐ Other _____

**Licensee**
Caressant-Care Nursing and Retirement Homes Limited

**Long-Term Care Home and City**
Caressant Care Fergus, Fergus

**Lead Inspector**
Katherine Adamski (#753)

**Inspector Digital Signature**
Katherine Adamski
Digitally signed by Katherine Adamski
Date: 2022.08.26 11:39:18 -04'00'

**Additional Inspector(s)**
Janet Evans (#659)
Richard Sutherland (MOL #02809) was present during this inspection

## INSPECTION SUMMARY

The inspection occurred on the following date(s): August 9 – 12, 15 – 17, 2022

The following intake(s) were inspected:

- Log #008815-22 related to a Proactive Compliance Inspection

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

- Falls Prevention and Management
- Food, Nutrition and Hydration
- Infection Prevention and Control (IPAC)
- Medication Management
- Pain Management
- Prevention of Abuse and Neglect
- Quality Improvement
- Resident Care and Support Services
- Residents' and Family Councils
- Safe and Secure Home
- Skin and Wound Prevention and Management

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## INSPECTION RESULTS

### NON-COMPLIANCE REMEDIED

***Non-compliance*** was found during this inspection and was ***remedied*** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154(2) and requires no further action.

**NC#01 remedied pursuant to FLTCA, 2021, s. 154 (2)**

**O. Reg. 246/22 s. 12 (3)**

The door leading to the Falls Equipment Room was neither closed nor locked to restrict unsupervised access by residents. The lock was faulty at the time of the observation.

The lock was repaired, and follow-up observations showed the door was closed and locked.

Date Remedy Implemented: August 10, 2022 [#753]

**NC#02 remedied pursuant to FLTCA, 2021, s. 154 (2)**

**O. Reg. 246/22, s. 79 (1) 1**

The daily menu was not posted outside of the small dining room. The week three summer menu was posted outside the small dining room and the week one winter menu was posted in the main dining room. Neither menu matched the served meal.

Nearing completion of the served meal, the correct daily and weekly menus were posted.

Date Remedy Implemented: August 9, 2022 [#659]

### WRITTEN NOTIFICATION COMMUNICATION AND RESPONSE SYSTEM

**NC#03 Written Notification pursuant to FLTCA, 2021, s. 154 (1)1**

**Non-compliance with: O. Reg. 246/22 s. 20 (d)**

The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that was available at each bed and toilet location used by residents.

**Rationale and Summary**

A resident's call bell was not activating. A Personal Support Worker (PSW) stated that the call bell was not functioning properly because it was plugged into a non-functional communication system.

Another resident did not have a call bell. The PSW stated that the call bell was broken, and that the Maintenance Supervisor was aware.

Three residents occupied two rooms with a shared bathroom. The call bell system in the shared bathroom did not have a string to engage the call bell system. One of the resident's estimated that the string had been missing for between two and four weeks, and stated that during the time it was missing, they feared they would not be assisted out of the washroom in time for meals.

Staff acknowledged the deficiencies with the call bells and stated that the Maintenance Department had been made aware. The Maintenance Supervisor stated that they were not aware of any concerns with any of the call bells, nor did they have any maintenance service requests related to the call bells.

When resident-staff communication and response systems were not available at each bed and toilet location used by residents, residents may not have been able to immediately alert staff of an emergency or request assistance.

**Sources:** Observations conducted on August 9, 10, 2022, interviews with the Maintenance Supervisor and other staff.

[#753]

## WRITTEN NOTIFICATION POWERS OF RESIDENTS' COUNCIL

**NC#04 Written Notification pursuant to FLTCA, 2021, s. 154 (1)1**

**Non-compliance with: FLTCA, 2021 s. 63 (3)**

The licensee has failed to ensure that they responded to the Residents' Council in writing, within 10 days when Residents' Council had advised the licensee of concerns or recommendations.

**Rationale and Summary**

A Resident's Council member stated that when concerns or recommendations were provided to the licensee, Residents' Council was not provided a response within 10 days of providing the advice, they would not be made aware until the next meeting, or approximately 30 days later.

The Resident's Council Liaisons stated that they were not aware of the requirement to share the response within 10 days until recently.

The home's "Outstanding Item Submission Form for Caressant Care Fergus Resident Council Meeting" stated that the feedback to concerns and recommendations from Resident's Council was to be presented at the next Resident's Council Meeting.

**Sources:** Outstanding Item Submission Form for Caressant Care Fergus Resident Council Meetings dated April 14, May 12, June 9, and August 11, 2022, interviews with a Resident's Council member and the Liaison.

[#753]

## WRITTEN NOTIFICATION RESIDENT AND FAMILY/CAREGIVER EXPERIENCE SURVEY

**NC#05 Written Notification pursuant to FLTCA, 2021, s. 154 (1)1**

**Non-compliance with: FLTCA, 2021 s. 43 (4)**

The licensee has failed to ensure that they sought the advice of the Residents' Council in carrying out the survey and in acting on its results.

**Rationale and Summary**

Residents' Council Meeting Minutes did not include documentation showing that Residents' Council was consulted before or after the resident satisfaction surveys were conducted.

The Administrator acknowledged that the licensee did not seek the advice of Residents' Council in carrying out the survey and acting on its results.

When Residents' Council was not consulted before or after resident satisfaction surveys were conducted, residents' input was not considered in formulating survey questions that were important to them and they were not able to act on the results.

**Sources:** Interviews with a Resident's Council member and the Administrator, Residents' Council Meeting Minutes dated April 14, May 12, June 9, and August 11, 2022.

[#753]

## WRIITEN NOTIFICATION GENERAL REQUIREMENTS FOR PROGRAMS

**NC#06 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

**Non-compliance with: O. Reg. 246/22 s. 34 (1)(3)**

The licensee has failed to ensure the home's pain management program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

**Rationale and Summary**

Documentation to substantiate that an annual Pain Management Program evaluation was conducted in 2021 or 2022 could not be provided. The Pain Management Program policies and procedures showed they were last reviewed in April of 2019.

The home's Administrator stated that they were not aware if the annual program evaluation had been conducted for the Pain Management Program in 2021.

When an annual program evaluation was not completed for the home's Pain Management Program, the program may not reflect evidence-based or prevailing practices.

**Sources:** Interviews with the Administrator and DOC, Pain Management Program (last reviewed April 2019).

[#753]

## WRITTEN NOTIFICATION INFECTION PREVENTION AND CONTROL PROGRAM

**NC#07 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

**Non-compliance with FLTCA, 2021 s. 23 (4)**

The licensee has failed to ensure that the home had an infection prevention and control (IPAC) Lead whose primary responsibility was the home's IPAC program.

**Rationale and Summary**

The home's Director of Care (DOC) who was also the home's designated IPAC Lead, stated that their primary responsibility in the home was as the DOC. The DOC was not sure how many hours they dedicated to IPAC related tasks per week, when the home's IPAC policies and procedures were last reviewed and revised, nor had they reviewed or familiarized themselves with the IPAC Standard, April 2022.

During the inspection, concerns related to staff knowledge and implementation of signage and Personal Protective Equipment (PPE) were noted.

A PSW was unsure how to interpret an Antibiotic Resistant Organism (ARO) precaution signage posted on a bedroom door. They did not know which resident the signage referred to, but stated they were required to don a gown regardless of which resident they were providing direct care for. Despite this, they acknowledged that they performed direct care to one of the two residents without donning a gown.

A Registered Nurse (RN) was not sure what the requirements were related to staff donning and doffing PPE for cohabited residents when one was on precautions. While the DOC/IPAC Lead stated that donning a gown was only required when providing direct care to an infected resident.

Additionally, signage on the door to another bedroom indicated the presence of an ARO. The signage did not indicate what PPE to don or who should wear the PPE.

A RN advised inspector #659 that additional PPE to enter the room was only required for individuals who were providing direct care to the residents in the room.

A PSW performed direct care in the room and stated that they did not need to wear a gown because the signage was indicated for the other resident in the room.

The signage on the door to the room was removed after the RN determined that neither resident had an ARO.

When the home did not have an IPAC Lead whose primary responsibility was IPAC, this may have contributed to the lack of knowledge and conflicting responses of staff regarding the use of PPE and proper posting of precautions signage. This put the residents, staff, and visitors at risk for disease transmission.

**Sources:** Observations on August 9, 12, 16, 2022, interviews with the DOC/IPAC Lead and other staff, IPAC Standard (April 2022).

[#659, #753]

## WRITTEN NOTIFICATION MEDICATION MANAGEMENT SYSTEMS

**NC#08 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

**Non-compliance with: O. Reg. 246/22 s. 138 (1) (b)**

The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

**Rationale and Summary**

The home's policy for medication storage documented narcotic and controlled (monitored) medications were to be triple locked (i.e., double locked in the cart or cabinet in a locked room).

The medication cart was in the north medication room which was locked. The cart was unlocked and the secure bin for the narcotic and controlled substances was unlocked.

A RPN acknowledged the medication cart and the bin for the narcotic and controlled medications were unlocked.

The medication cart on the central medication room was in a locked room, but the cart was unlocked and the bin with the controlled substances and narcotics was locked.

The RPN stated that they could not lock the cart as there was only one set of keys and the RN may need to access medications.

Not ensuring that the narcotic and controlled substances were secured in a locked area in a double locked cart increased the risk of narcotics and controlled substances going missing.

**Sources:** Observations on August 16, 2022, the home's Medication Storage policy 3-4, revised 1-18, interviews with an RPN and other staff.

[#659]

**NC#09 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

**Non-compliance with: O. Reg. 246/2 s. 124 (1)**

The licensee failed to ensure that an interdisciplinary team which included the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, met at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

**Rationale and Summary**

Documentation to substantiate a quarterly evaluation of the effectiveness of the medication management system for the home and to recommend any changes necessary to improve the system could not be provided for 2022.

The last documented evaluation was completed May 4, 2021, during the Professional Advisory Committee (PAC) Meeting.

The Administrator acknowledged that there had not been a meeting of the PAC in 2022.

When the required interdisciplinary team did not meet at least quarterly to evaluate the effectiveness of the medication management system in the home and recommend changes to improve the system, there was a missed opportunity to effect positive change that may have improved residents' health and well being.

**Sources:** PAC Meeting minutes May 4, 2021, interviews with the Administrator and DOC.

[#659]

**NC#010 Written Notification pursuant to FLTCA, 2021, s. 154(1)1**

**Non-compliance with: O. Reg. 246/2 s. 147 (3)(c)**

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The licensee failed to maintain a written record of the changes and improvements that were implemented following the quarterly medication review completed for quarter two (Q2) of 2022.

**Rationale and Summary**

The quarterly medication review for Q2 documented that most of the medication errors were made by the same registered staff. Actions taken or planned included that the evening medication pass was to be monitored more frequently for the identified staff.

The DOC stated that they worked in the evening and had monitored/audited the medication pass, but this had not been documented.

Not documenting the changes and improvements implemented was a missed opportunity for the home to record and track what had been successful in addressing concerns for their medication program.

**Sources:** Medication Error Analysis Q2, monthly Continuous Quality Improvement meeting minutes, interview with the DOC.

[#659]