Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901

Original Public Report

Report Issue Date: May 5, 2023	
Inspection Number: 2023-1114-0003	
Inspection Type: Complaint Critical Incident System	
Licensee: Caressant-Care Nursing and Retirement Homes Limited	
Long Term Care Home and City: Caressant Care Fergus Nursing Home, Fergus	
Lead Inspector Jessica Bertrand (722374)	**Inspector Digital Signature** Jessica F Bertrand Digitally signed by Jessica F Bertrand Date: 2023.05.09 08:51:36 -04'00'
Additional Inspector(s) Alicia Campbell (741126) Amanpreet Kaur Malhi (741128)	

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): April 24-28, 2023.

The following intakes were inspected:

- Intake #00085012 related to fall prevention and management;
- Intake #00015255 related to allegations of staff to resident abuse;
- Intake #00022501 related to allegations of neglect related to wound care;
- Intake #00021003 (Complaint) related to allegations of improper care.

The following intakes were completed in this inspection:

- Intake #00014198 and intake #00017124 related to falls prevention and management.

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

Resident Care and Support Services
Infection Prevention and Control
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Duty to Protect

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that a resident was not neglected by a staff member.

For the purposes of the Act and Regulations, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Rationale and Summary
On a specified date, a staff member identified that a resident had a change in condition. The staff member did not report this to a registered staff member.

Later in the day, a registered staff member became aware that the resident had a change in condition from someone else, and an assessment was completed at that time identifying further changes.

The Director of Care (DOC) indicated that the staff member should have reported the resident's change in condition to a registered staff member immediately. They stated that even half an hour of inaction could have jeopardized the resident's health and safety.

The failure of the staff member to notify a registered staff member regarding the resident's change in condition delayed a clinical assessment being completed and put the resident's health and safety at risk.

Sources: A resident's progress notes; interviews with a staff member, registered staff member, Resident Care Coordinator (RCC) and the DOC.

[741126]

WRITTEN NOTIFICATION: Plan of Care

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that the care set out in the plan of care for a resident was provided to

the resident as specified in the plan.

Rationale and Summary
A resident was ill on multiple days, and the physician ordered lab work for the resident.

The resident refused to have samples obtained, and the lab work was re-scheduled.

The lab work was not completed at the re-scheduled time, and there was no documentation to indicate the reason for this.

The resident was later found to have abnormal lab work and had further change in condition.

The DOC indicated that not completing the lab work put the resident at risk as the home was unable to identify what the cause of the resident's change in condition was and treat accordingly.

Failing to complete lab work as ordered by the physician potentially delayed the identification of condition and subsequent treatment for the resident.

Sources: a resident's progress notes; a resident's lab requisition form; interview with a registered staff member and the DOC.

[741126]

WRITTEN NOTIFICATION: Reporting Certain Matters to Director

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.

The licensee has failed to ensure that a person who had reasonable grounds to suspect abuse of a resident immediately reported it to the Director.

In accordance with FLTCA, 2021, s. 154(3), where an inspector finds that a staff member has not complied with subsection 28 (1) or 30 (1), the licensee shall be deemed to have not complied with the relevant subsection and the inspector shall do at least one of the actions set out in subsection (1) as the inspector considers appropriate.

Rationale and Summary

The home submitted a Critical Incident (CI) report to the Director reporting allegations of abuse by a staff member towards a resident.

The alleged incidents of abuse towards the resident was discovered on a specified date. A staff member, who learned of the incidents, did not report it to management at that time.

The Executive Director (ED) acknowledged that the allegations should have been reported immediately to the Director when they were discovered.

By failing to report the allegation of abuse immediately, the Director was unable to respond to the incident in a timely manner.

Sources: a CI report, the home's investigation notes, interviews with a registered staff member and ED.

[722374]