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: November 10, 2023

Inspection Number: 2023-1114-0006

Inspection Type:
Complaint
Critical Incident
Follow up

Licensee: Caressant-Care Nursing and Retirement Homes Limited

Long Term Care Home and City: Caressant Care Fergus Nursing Home, Fergus

Lead Inspector	**Inspector Digital Signature**
Alicia Campbell (741126)	Alicia Campbell Digitally signed by Alicia Campbell Date: 2023.11.14 14:30:53 -05'00'

Additional Inspector(s)
Megan Brodhagen (000738)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): October 24-27, 30-31, and November 1-2, 2023

The following intake(s) were inspected:

- Intake #00089768 - related to staff to resident abuse.
- Intake #00097712 - related to staff to resident improper care.
- Intake #00099813 - related to improper/incompetent care of a resident.
- Intake #00099497 - Complaint related to care concerns.
- Intake #00096507, Follow-up #1 - High Priority CO #001 / 2023_1114_0005, O. Reg 246/22 s. 146 (a), residents' drug regimes, CDD October 11, 2023, no RIF.

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1114-0005 related to O. Reg. 246/22, s. 146 (a) inspected by Megan Brodhagen (000738)

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

Continence Care
Resident Care and Support Services
Medication Management
Food, Nutrition and Hydration
Infection Prevention and Control
Whistle-blowing Protection and Retaliation
Prevention of Abuse and Neglect
Reporting and Complaints
Falls Prevention and Management

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 #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
FLTCA, 2021, s. 6 (1) (c)

The licensee has failed to ensure that there was a written plan of care for a resident that set out clear directions to staff and others who provided direct care to the resident.

A resident was assessed to require a certain level of assistance for transferring. The logo posted near their bed indicated a different level of assistance with transferring than what was stated in their written care plan.

An assistive device for ambulation was observed in the residents room, however, the resident was seen to be using a different assistive device for ambulation. Their written plan of care did not indicate which device they were to be using.

The residents plan of care was updated to provide clear direction on the resident's transfer and ambulation status.

Sources: Resident documents and observations; Interviews with staff.

[741126]

Date Remedy Implemented: November 1, 2023

WRITTEN NOTIFICATION: Transferring and positioning techniques

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 40

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting a resident.

Rationale and Summary
During a transfer of a resident, two PSW's did not follow the residents plan of care in regards to the level of assistance and equipment that was required for the transfer.

Failure to use the transferring technique that the resident was assessed for put the resident at risk for harm.

Sources: Resident's documents; Interview with staff.

[741126]

WRITTEN NOTIFICATION: Continence care and bowel management

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 56 (2) (b)

The licensee has failed to ensure that each resident who was incontinent had an individualized plan, as part of their plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

Rationale and Summary
A PSW did not implement the appropriate interventions as per a residents plan of care when providing them with continence care.

Another PSW indicated that the actions taken by the above PSW during continence care for the resident were not normal practice and were not part of the residents plan of care.

The resident stated that the incident had made them upset and feel as though they had done something wrong.

Sources: Resident's documents; Interviews with the resident and staff; homes investigation notes.

[741126]