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: March 6, 2024

Inspection Number: 2024-1114-0001

Inspection Type:
Complaint
Critical Incident

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**
Amanpreet Kaur Malhi (741128)	Amanpreet K Malhi Digitally signed by Amanpreet K Malhi Date: 2024.03.20 10:56:36 -04'00'

Additional Inspector(s)
Nuzhat Uddin (532)
Gurvarinder Brar (000687)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): January 16-19, 22-26, 30-31, 2024 and February 1-2 and 6-7, 2024.

The following intake(s) were inspected:

- Intake: #00102276, CI #2603-000051-23, related to COVID-19 outbreak
- Intake: #00102781, CI #2603-000054-23, related to fall
- Intake: #00101770, CI #2603-000042-23, related to multiple allegations of improper care/Abuse of a resident
- Intake: #00101909, CI #2603-000046-23, related to improper resident care

- Intake: #00101911, CI #2603-000044-23, related to improper continence care
- Intake: #00100426, CI #2603-000040-23, and Intake: #00101908, CI #2603-000049-23, related to visitor to resident abuse.
- Intake: #00101683, complaint related to resident's care neglect
- Intake: #00102174, complainant related to an assessment of a resident and IPAC related concern
- Intake: #00102336, complainant related to concerns re: skin and wound assessment and bathing

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

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

INSPECTION RESULTS

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that when there were reasonable grounds to suspect that abuse had occurred, that they immediately reported the suspicion and the information upon which it was based to the Director.

Rational and Summary
Staff suspected abuse towards resident #002, however, the incident was reported to the Ministry twenty days later.

Sources: a CI report, and Interviews with staff [000687]

WRITTEN NOTIFICATION: Binding on licensees

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 184 (3)
Directives by Minister
s. 184 (3) Every licensee of a long-term care home shall carry out every operational or policy directive that applies to the long-term care home.

The licensee failed to comply with the Minister's Directive: they failed to notify their local public health unit as soon as possible of all confirmed and probable resident cases of COVID-19.

Rationale/Summary
In accordance with the Minister's Directive:COVID-19 response measures for long-term care homes, effective August 30, 2023 and the COVID-19 guidance document for long-term care homes in Ontario, updated November 7, 2023; homes must notify

the local public health unit of all confirmed and probable resident cases of COVID-19 as soon as possible.

The home had two residents with positive COVID-19 Rapid Antigen Test (RAT) on a specified date. The local Public Health Unit was not notified of the suspected and confirmed COVID-19 resident cases immediately.

Not reporting suspected or confirmed resident COVID-19 positive cases/outbreak to the local Public Health Unit as soon as possible, may have delayed putting the infection control measures in place.

Sources: Resident's clinical records, Email record from Public Health Nurse, Minister's Directive: COVID-19 response measures for long-term care homes, COVID-19 guidance document for long-term care homes in Ontario and Interviews with staff [741128]

WRITTEN NOTIFICATION: Bathing

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 37 (1)
Bathing
s. 37 (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 their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The licensee failed to ensure that resident #003 was bathed, at a minimum, twice a week by the method of their choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Rationale and Summary
A complaint was received regarding resident #003 not receiving their baths at times due to a shortage of staffing.

Upon review of the resident's bathing documentation for a specified period, it was noted that staff had documented, "not applicable" for specific days the resident was scheduled for a bath.

Staff acknowledged that they were short staff during the specified period and could not provide the resident their choice of bath, and therefore, they documented not applicable.

When resident #003 was not given a bath by their preferred method at least twice a week, the home failed to provide an alternative arrangement, putting the resident at risk of skin and hygiene issues.

Sources: Resident #003's clinical records, staffing report for a specified period, and interviews with staff [532]

WRITTEN NOTIFICATION: Administration of drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 140 (2)
Administration of drugs
s. 140 (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 246/22, s. 140 (2).

The licensee failed to ensure that as needed (PRN) bowel protocol was correctly

followed /implemented for resident #001 as specified by the prescriber.

Rationale and Summary
The sequence of interventions outlined in Resident #001's bowel protocol were not followed or implemented correctly during a specified period of no bowel movement.

Executive Director (ED) #100 stated that staff should have tried other interventions.

Failure to adhere to the prescribed bowel protocol may have contributed to resident #001's prolonged constipation, and discomfort.

Sources: Resident #001's clinical records, and interview with ED #100 [741128]

COMPLIANCE ORDER CO #001 Residents' Bill of Rights

NC #005 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 3 (1) 16.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
16. Every resident has the right to proper accommodation, nutrition, care and services consistent with their needs.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. Educate the management and nursing staff about the rights of the Power of Attorney (POA)/Substitute Decision Maker (SDM) and residents in relation to decision making. Include, how their rights must be balanced with ensuring the resident receives proper care and services. Document the education including the date, format and staff attending the training, including the staff member who provided the education.
2. Re-educate the specific staff on the medication administration protocols. Document the education, including the date and staff member who provided the education and method used to assess their understanding and knowledge.

Grounds

The licensee failed to ensure that resident #001's right to proper care and services consistent with their needs was fully respected and promoted.

Rationale and Summary

Resident #001 was dependent on their Substitute Decision Maker (SDM) for making decisions regarding their care.

A) Resident #001 was fed in a manner that put them at risk. No follow-up or additional strategies were implemented when this continued to occur.

B) Resident #001 was provided care in a manner that placed them at risk. No measures were put in place to prevent this from occurring again.

C) The resident did not receive medications or care as per their plan of care on a specified date.

The resident was later hospitalized with concerns that may have been prevented or minimized had the plan of care been followed.

When the home failed to provide resident #001 proper care and services consistent with their care needs, this may have contributed to the decline in health of the resident.

Sources: Resident #001's clinical records, Groves Memorial Community Hospital Records, and interviews with staff [741128]

This order must be complied with by April 18, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect

to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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