Ministry of Health and Long-Term Care

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Ministère de la Santé et des Soins de longue durée

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Ontario

January 25, 2017

DELIVERED BY HAND

Mr. James Lavelle, President,
Caressant Care Nursing and Retirement Homes Ltd.
254 Norwich Avenue
Woodstock, ON N4S 3V9

Dear Mr. Lavelle:

Re: Suspension of Admissions to Caressant Care Woodstock Nursing Home

I am writing to notify you that pursuant to section 50 of the *Long-Term Care Homes Act, 2007* (LTCHA), I have directed the Southwest Community Care Access Centre (CCAC), the placement co-ordinator for Caressant Care Woodstock Nursing Home, to cease authorizing admissions to Caressant Care Woodstock Nursing Home. This direction is effective January 26, 2017 until further notice from the Director under the LTCHA.

Before admissions may be reinstated the Licensee must provide evidence to satisfy me that all of the required actions in the following Orders associated with the identified Inspections listed below have been completed, and that the Orders have been returned to compliance:

Order #001	Inspection # 2016_229213_0035
Order #002	Inspection # 2016_229213_0035
Order #001	Inspection # 2016_303563_0042
Order #002	Inspection # 2016_303563_0042
Order #003	Inspection # 2016_303563_0042
Order #004	Inspection # 2016_303563_0042
Order #001	Inspection # 2016_229213_0038
Order #002	Inspection # 2016_229213_0038

I am directing the ceasing of admissions based on my belief that there is a risk of harm to the health or well-being of residents in the home or persons who might be admitted as residents.

My belief is based on information provided to me by Ministry inspectors that was gathered in recent inspections. In these inspections, Ministry inspectors identified a significant number of findings of non-compliance with requirements under the LTCHA and O. Reg 79/10. Specifically, during inspections conducted between October 2016 and January 2017, Ministry inspectors issued a number of compliance orders and determined that the licensee had not complied with two compliance orders that were to be complied with by August 4, 2016 and October 31, 2016 respectively. As a result, both of these compliance orders have been re-issued.

The findings of non-compliance, as well as the Orders referenced above, identified by Ministry inspectors in recent inspections include, but are not limited to:

- Recurring non-compliance by the licensee related to:
    - Failure to report suspected abuse and neglect of residents; and
    - Failure to ensure plans of care for specific residents who use motorized wheelchairs were based on an assessment of safety risks.
- Failure to investigate all alleged, suspected or witnessed incidents of abuse or neglect of residents that the licensee knows of or that were reported to the licensee.
- Failure to ensure that medication is administered to residents in accordance with the directions given by the prescriber.
- Failure to ensure that all medication incidents and adverse reactions are documented, reported, investigated and appropriate action taken.
- Failure to ensure residents with skin breakdown, pressure ulcers, skin tears or altered skin integrity receive a skin and wound care assessment using a clinically appropriate assessment tool, and that there is a weekly re-assessment if clinically indicated.
- Failure to ensure residents receive individualized personal care, including hygiene care and grooming on a daily basis.
- Failure to ensure that the following required components of the plan of care are in place, including:
    - Ensuring that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it; and
    - Ensuring that residents are re-assessed and plans of care reviewed and revised at least every six months and at any other time as required by the legislation.

Given the seriousness of the non-compliance identified by the Ministry inspectors and given the number of Orders issued, I expect that the licensee will ensure action is taken to address all of the outstanding non-compliance promptly.

In order to ensure this occurs, I am requesting that a written plan be submitted to me by **February 1, 2017**. I expect that the plan will outline steps the licensee has taken and will take to correct all outstanding non-compliance to address the risk of harm to the health or well-being of residents or persons who might be admitted as residents. I also expect that the plan will identify the steps being taken by the licensee to ensure there is experienced and skilled leadership in place at Caressant Care Woodstock to carry out this plan and ensure all outstanding non-compliance is addressed, and that compliance with the LTCHA and O. Reg 79/10 is sustained

In addition to the above, I require that you, as licensee, will meet with the Residents' Council and Family Council at the home no later than **February 15, 2017** to review the plan identified above, and to obtain input from the members of each Council. Please confirm with me in writing no later than February 28, 2017 that the meeting(s) have taken place and provide me with any updates to your plan as a result of input from the Residents' Council and Family Council.

As there are other inspections that are currently ongoing and follow-up inspections which are still to occur, additional risk areas may be identified. As a result, there may be additional actions that the licensee may be required to complete beyond those identified in this letter before admissions may be re-instated. Any additional requirements will be communicated should additional risks be identified.

If you have any questions, please contact Peggy Skipper, LSAO Manager, at (519) 873-1299 or Mary Nestor, Senior Manager, Long-Term Care Inspections Branch at (905) 896-4143.

Sincerely,

Karen Simpson
Director under the *Long-Term Care Homes Act, 2007*
Long-Term Care Inspections Branch

c. Michael Barrett, CEO, Southwest LHIN
Gay Goetz, Acting Administrator, Caressant Care Woodstock
Jane Sager, Director, LHIN Liaison Branch, MOHLTC
Mary Nestor, Senior Manager, Compliance and Enforcement, LTCIB, MOHLTC
Peggy Skipper, Manager, London SAO, LTCIB, MOHLTC