Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Central West Service Area Office
500 Weber Street North
WATERLOO ON N2L 4E9
Telephone: (888) 432-7901
Facsimile: (519) 885-9454

Bureau régional de services du Centre-Ouest
500 rue Weber Nord
WATERLOO ON N2L 4E9
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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 27, 2018	2018_755728_0007	007263-17, 027026-17, 028676-17, 001546-18, 025795-18	Complaint

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue WOODSTOCK ON N4S 3V9

Long-Term Care Home/Foyer de soins de longue durée

Cambridge Country Manor
3680 Speedsville Road, R.R. #1 CAMBRIDGE ON N3H 4R6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

MARIA MCGILL (728), NUZHAT UDDIN (532)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 6, 7, 10, 11, 12, 14, 17, 18, 19, 20, 2018

The following intakes were completed as part of this inspection:
Log #007263-17 related to staff to resident abuse
Log #027026-17 / IL-54284-LO a complaint related to falls, prevention of abuse/neglect, protection from certain restraining, and plan of care
Log #028676-17/ IL-54545-LO, a complaint related to plan of care, safe and secure home, short staffing, potential misuse of funding
Log #001546-18 / IL-55073-LO, a complaint related to responsive behaviours and notification of the substitute decision maker (SDM)
Log #025795-18 related to alleged staff to resident abuse

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), the Assistant Director of Nursing (ADON), a Nurse Practitioner (NP), the RAI Coordinator, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), a Physiotherapy Assistant (PTA), and employees of a security company.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

The licensee failed to ensure that the written policy to promote zero tolerance of abuse

and neglect of residents was complied with. 2007, c.8, s.20(1).

The home's abuse policy titled “Abuse & Neglect – Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff", last reviewed August, 2018, stated that “all cases of suspected or actual abuse must be reported immediately to the DOC/Executive Director. In the absence of management staff, concerns should be reported immediately to the Charge Nurse, who will notify management on call.” Assistant Director of Nursing (ADON) said that they are not able to access the policy from 2017 since it had been updated but that the expectation for reporting was the same at that time.

A) A complainant reported an incident that occurred between a resident and a PSW. The incident was thought to have occurred during an identified year. The complainant alleged that the PSW said a negative comment to the resident that threatened neglect and included profanity and name calling. The complainant said that they told a registered staff member about the incident.

The registered staff member that was told about the incident said they did recall being told about it but thought they had clarified with the complainant that it had been reported to the management of the home.

The Executive Director (ED) said that they were not made aware of this allegation until now.

The ADON said that it would have been the expectation of the staff member to report the allegation of abuse to the home's management or Charge Nurse in the absence of management, and that their policy was not complied.

B) A critical incident (CI) report was submitted on an identified date, related to staff to resident abuse.

The correspondence sent to the ED and the Director of Care (DOC) on an identified date, outlined the complaint of alleged abuse and stated that a former PSW witnessed the incident.

A review of the home's document titled “Report of Complaint”, undated, stated that the PSW did not disclose the incident to the management or Charge Nurse because another

person who knew about the incident had indicated to them that they would like to speak with management themselves.

In an interview with the Executive Director, they said that in this situation, the home's policy was not complied.

The licensee failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents was complied with. [s. 20. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

The licensee has failed to ensure that residents were protected from abuse by anyone.

On an identified date, correspondence was sent to the Executive Director (ED) and Director of Care (DOC) alleging that on an identified date, a Personal Support Worker (PSW) was short tempered and annoyed with the resident and that the PSW treated the resident roughly which made them feel afraid. The correspondence states that the resident was shaken up and distraught about the incident.

A review of the the home's investigation concluded that the staff member behaved in an abusive manner and the resident was upset by the PSW's actions.

An RN said that treating a resident roughly and providing care against their wishes is considered to be abuse.

The ED said that they submitted a Critical Incident (CI) report for this incident because they considered it to be abuse.

The licensee has failed to ensure that the specified resident was protected from abuse by anyone. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents are protected from abuse by anyone, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (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:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

The licensee failed to ensure that a person who has reasonable grounds to suspect abuse of a resident by anyone that has occurred or may occur immediately reported the suspicion and the information on which it is based to the Director.

A Critical Incident (CI) report was submitted on April 5, 2017, related to staff to resident verbal abuse. The CI documented that the home received correspondence on April 2, 2017, alleging that on March 23, 2017, an incident or emotional and verbal abuse occurred. The CI also documented that on April 4, 2018, incidences of verbal abuse occurred.

The home's document titled "Report of Complaint" documented that the Executive Director (ED) was on vacation and that the DOC read the e-mail on April 2, 2017.

The ED said that they submitted a Critical Incident (CI) report because they thought the incident was abuse; however, the investigation determined that the alleged abuser did not intend their actions to be that way. The ED said that the incident occurred on March 23, 2017, the e-mail was received on April 2, 2018, and that the incident was reported to the Director through a CI on April 5, 2018.

The licensee failed to ensure that a person who has reasonable grounds to suspect abuse of a resident by anyone that has occurred or may occur immediately reported the suspicion and the information upon which it is based to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any person who has reasonable grounds to suspect abuse of a resident by anyone that has occurred or may occur is immediately reported the suspicion and the information on which it is based to the Director, to be implemented voluntarily.

Issued on this 29th day of October, 2018

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	MARIA MCGILL (728), NUZHAT UDDIN (532)
Inspection No. / No de l'inspection :	2018_755728_0007
Log No. / No de registre :	007263-17, 027026-17, 028676-17, 001546-18, 025795-18
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Sep 27, 2018
Licensee / Titulaire de permis :	Caressant-Care Nursing and Retirement Homes Limited 264 Norwich Avenue, WOODSTOCK, ON, N4S-3V9
LTC Home / Foyer de SLD :	Cambridge Country Manor 3680 Speedsville Road, R.R. #1, CAMBRIDGE, ON, N3H-4R6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Heather Richardson

To Caressant-Care Nursing and Retirement Homes Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Order / Ordre :

The licensee must be complaint with s. 20 (1) of the LTCHA.

Specifically, the licensee must:
a) comply with their home's abuse and neglect policy and related procedures for reporting incidents of alleged, suspected, or witnessed abuse.
b) ensure that all staff are aware and follow the reporting process as outlined in their policy.

The severity of this issue was determined to be a level 2 as there was minimal harm/potential for actual harm. The scope of the issue was a level 2 as it related to two out of five incidences. The home had a level 3 history as they had previous non-compliance in the past 36 months that included:
- voluntary plan of correction (VPC) issued October 16, 2017 (2017_607523_0023).

Grounds / Motifs :

1. The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with. 2007, c.8, s.20(1).

The home's abuse policy titled "Abuse & Neglect – Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff", last reviewed August, 2018, stated that "all cases of suspected or actual abuse must be reported immediately to the DOC/Executive Director. In the absence of management staff, concerns should be reported immediately to the Charge Nurse, who will notify management on call." Assistant Director of Nursing

(ADON) said that they are not able to access the policy from 2017 since it had been updated but that the expectation for reporting was the same at that time.

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In an interview with the Executive Director, they said that in this situation, the home's policy was not complied.

The licensee failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents was complied with. [s. 20. (1)] (728)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

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 was served on the Licensee.

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The 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 a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 27th day of September, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Name of Inspector /
Nom de l'inspecteur : Maria McGill

Service Area Office /
Bureau régional de services : Central West Service Area Office