



**Ministry of Health and  
Long-Term Care**

**Ministère de la Santé et des  
Soins de longue durée**

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

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

**Health System Accountability and  
Performance Division  
Performance Improvement and  
Compliance Branch**

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**Division de la responsabilisation et de la  
performance du système de santé  
Direction de l'amélioration de la  
performance et de la conformité**

**Public Copy/Copie du public**

<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / Registre no</b>	<b>Type of Inspection / Genre d'inspection</b>
Apr 29, 2014	2014_181105_0015	L-000286-14	Critical Incident System

**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**

CARESSANT CARE ARTHUR NURSING HOME  
215 ELIZA STREET, P.O. BOX 700, ARTHUR, ON, N0G-1A0

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

JUNE OSBORN (105)

**Inspection Summary/Résumé de l'inspection**



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**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): April 23, 24, 2014**

**This inspection also included L-000332-14, L-000430-14, and L-0000452-14**

**During the course of the inspection, the inspector(s) spoke with 6 Residents, the Assistant Director of Care, the RAI Coordinator, 2 Personal Support Workers, the Director of Care, and the Administrator.**

**During the course of the inspection, the inspector(s) reviewed 4 Critical Incident Reports, reviewed 4 medical records, reviewed staff education records, and observed interactions between staff and residents.**

**The following Inspection Protocols were used during this inspection:  
Prevention of Abuse, Neglect and Retaliation**

**Findings of Non-Compliance were found during this inspection.**



**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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.



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**WN #1: 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).**

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**Findings/Faits saillants :**

1. The licensee has not ensured the alleged neglect of a resident by staff was reported immediately to the Director.

The incident occurred April 1, 2014. It was reported to the Director of Care April 2, 2014 who reported the alleged neglect to the Director April 3, 2014.

This was confirmed by the Director of Care. [s. 24. (1)]

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**Issued on this 29th day of April, 2014**

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