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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jun 17, 2016	2016_450138_0014	012435-16, 012375-16, 011635-16	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 BOURGET
2279 Laval Street P.O. Box 99 Bourget ON K0A 1E0

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

PAULA MACDONALD (138)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 10, 11, and 12, 2016.

Three critical Incidents were inspected, one relating to an injury to a resident, the second relating to inappropriate touching from one resident to another, and the third related to resident to resident abuse with injury.

During the course of the inspection, the inspector(s) spoke with residents, registered nurses, registered practical nurses, personal support workers, a physician, a nursing clerk, the Administrator, and the Director of Care.

While in the home, the Inspector reviewed resident health care records, reviewed the process for reporting of behaviours, and toured the dining room.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **0 VPC(s)**
- **0 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 O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to comply with section 26.(3)5. of the legislation in that the license failed to ensure that the plan of care is based on any identified responsive behaviours for resident #004.

Critical Incident Report was submitted by the home and outlined that a resident was observed to inappropriately touch resident #004. Resident #004's health care record was reviewed in response to this Critical Incident Report. It was noted in the progress notes of resident #004's health care record that the resident has a history of disrobing and inappropriately dressing. The health care record outlined that medications were changed for the resident early in 2016 to aid in managing this behaviour. Staff report that the resident's behaviours have improved since the medication changes but that the behaviour still exists.

The current plan of care for the resident was reviewed. It outlined a diagnosis of mental disorder illness and described various problematic behaviours. The plan of care, however, did not outline the resident's behaviour of disrobing/dressing inappropriately nor did it outline interventions in place to manage such behaviour.

(011635-16) [s. 26. (3) 5.]

Issued on this 17th day of June, 2016

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

Original report signed by the inspector.