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

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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
Jan 13, 2017	2017_603194_0002	026689-16, 031781-16, 033363-16, 035059-16	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 LINDSAY NURSING HOME
240 MARY STREET WEST LINDSAY ON K9V 5K5

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

CHANTAL LAFRENIERE (194)

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): onsite inspection January 3, 4, 5, offsite inspection January 9 and 10, 2017

The inspector inspected Log #026689-16, #033363-16, #031781-16 related to allegations of resident to resident verbal abuse and Log #035035-16 related to resident fall

During the course of the inspection, the inspector(s) spoke with Administrator, Acting Director of Nursing (DON), Resident Care Coordinator (RCC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW) and Residents

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an assessment of the resident and the resident's needs and preferences

On an identified date, resident #004 fell in the bathroom. An assessment was completed by RPN #110 post fall with no evidence to support any injury as a result of the fall. The following day a specific assessment was completed for resident #004. RPN #110 received the results of the specific assessment two days later. RPN #110 faxed the results of the specific assessment which indicated an injury for resident #004 to the physician's office. Three days later another RPN assessed resident for concerns related to injury. The Physician was in to assess resident and orders received to transfer resident to hospital where treatment for injury was provided.

RPN #110 did not follow up with RN #114 or DON when results from specific assessment was received for resident #004 which indicated an injury. RPN #110 faxed the results to the physician's office which DON and RN # 114 have indicated to inspector # 194 is not the usual practice at the home. RPN #110 did not ensure care for resident #004 based on the results of the specific assessment which indicated injury. Treatment for resident #004's injury was delayed by three days. [s. 6. (2)]

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 by ensuring that the plan of care for resident #004 is based on resident's needs and preferences, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) Identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) Identifying and implementing interventions.

Resident #001 had been diagnosed with cognitive impairments. Resident #001 requires staff assistance for ADL's, is wheelchair dependent but able to self propel independently in the home.

On an identified date an assessment for resident #001 was requested by the home and conducted by external source related to increased verbally aggressive and sexually inappropriate behaviour exhibited towards staff and co residents at the home. Recommendations were provided by external source for resident #001 post assessment.

Review of resident #001's clinical health records was conducted by inspector #194 and indicated that the recommended by external source included;
-staff to give clear and firm direction, addressing resident #001 with respect, being clear in expectations and the plan moving forward.
-consider events and approaches that contributed to positive behaviour response and reinforce using these interventions.
-if care cannot be managed and risk becomes acute it is the responsibility of the home to arrange 1:1 observation.
-Involve police community relations officer as needed to re-enforce appropriate behaviour.

Review of the clinical health record for resident #001 as well as the following Critical Incident Reports (CIR) submitted to the Ministry of Health related to responsive behaviours was completed by inspector #194;
-CIR for incident of verbal abuse involving resident #001 and co residents #002, #003
-CIR for incident of verbal abuse dated three months (after initial CIR inspected) involving resident #001 and resident #006

-CIR for incident of verbal abuse dated three months (after initial CIR inspected) involving resident #001 and resident #002
-Resident #001's progress notes dated one month later describing an incident of alleged sexual abuse involving resident #005.

During separate interviews with inspector #194 on January 3, 4 and 5, 2017, Acting DON, Administrator, RCC, RN #114, PSW #119, PSW #117 and PSW #118 indicated that resident #001 had demonstrated verbally abusive behaviour towards resident #002, #003 and #006 over a four month period, as well as being sexually inappropriate towards new female admissions at the home.

During separate interviews with inspector #194 on January 3,4 and 5, 2017, PSW #117, #118 and #119 staff indicated to inspector that they were not aware of the details outlined in the plan of care related to resident #001 such as; the need to be away from specific residents at the home. PSW #117, #118, #119 also indicated that when resident #001 was being verbally abusive towards co resident and staff intervened, resident #001 was not always compliant with being removed from the area.

Review of resident #001's plan of care identified that verbally abusive incidents involving co residents had occurred and that staff were to monitor. The plan of care did not identify triggers or interventions to minimize the risk of altercation between co residents. The plan of care did not indicate how monitoring of resident #001 was to be completed or by whom.

Review of the plan of care for resident #001 did not identify the risk of female residents who are new admissions to the home, or include the recommendations provided by external source, to use a firm and clear approach with resident #001. The plan of care did not provide interventions or strategies for staff when resident #001 was being non compliant related to being moved out of an abusive situation involving co-residents. [s. 54. (a)]

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 by ensuring that steps are taken to minimize the risk of altercation and potentially harmful interactions between resident #001 and co residents, by identifying factors that could potentially trigger altercations and identify and implement interventions, to be implemented voluntarily.

Issued on this 13th day of January, 2017

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

Original report signed by the inspector.