



**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**

**Division de la responsabilisation et de la
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Direction de l'amélioration de la
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 2, 2014	2014_253514_0040	L-001533-14	Resident Quality Inspection

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 LISTOWEL NURSING HOME
710 RESERVE AVENUE SOUTH, LISTOWEL, ON, N4W-2L1

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

RUTHANNE LOBB (514), CHRISTINE MCCARTHY (588), JUNE OSBORN (105)

Inspection Summary/Résumé de l'inspection



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The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 24-28 and December 1, 2014

Concurrent Critical Incident Inspections (002862-14, 000082-14, 007171-14, 002064-14) were conducted.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Nursing, Food Services Manager, Resident Assessment Instrument Coordinator, Maintenance/Environmental, Physiotherapist, 2 Registered Nurses, 1 Registered Practical Nurse, 1 Dietary Aide, 7 Personal Support Workers, 3 Family Members and 40+ Residents.

During the course of the inspection, the inspector(s) toured all resident home areas, observed dining service, medication administration, provision of resident care, recreational activities, resident/staff interactions, infection prevention and control practices, reviewed residents' clinical records, posting of required information, meeting minutes related to the inspection and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

**Accommodation Services - Housekeeping
Contenance Care and Bowel Management
Dining Observation
Falls Prevention
Food Quality
Infection Prevention and Control
Medication
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care**

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.

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 17.
Communication and response system**



Specifically failed to comply with the following:

- s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
- (a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
 - (b) is on at all times; O. Reg. 79/10, s. 17 (1).
 - (c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
 - (d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
 - (e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
 - (f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
 - (g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home is equipped with a resident-staff communication and response system that, e) is available in every area accessible by residents as evidenced by:

During a tour of all home areas, it was observed that a resident-staff communication was not available in the two dining areas, the small lounge by the front door, or the family room by the front door.

This finding was confirmed by the Administrator, who shared that a quote had been obtained to have these call bells installed, however, has not yet obtained approval from head office to proceed with the work. [s. 17. (1) (e)]

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 the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents,, to be implemented voluntarily.



WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the results of the abuse and neglect investigation were reported to the Director, as evidenced by:

On a specified date, a Critical Incident Report was submitted, reporting alleged abuse. The Critical Incident Report did not have any amendment made by the home, reporting the home's investigative results.

The Administrator confirmed there were no investigative results submitted to the Director. [s. 23. (2)]

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 :

1. The licensee has failed to ensure that a report by a resident of alleged abuse was reported immediately to the Director, as evidenced by:

On a specified date, the Administrator was made aware of an alleged abuse involving a resident. A Critical Incident Report was submitted a day late.

The Administrator verified she submitted the Critical Incident Report the day after the incident was reported to her, and confirms she did not immediately notify the Director of the alleged abuse. [s. 24. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 96. Policy to promote zero tolerance

Every licensee of a long-term care home shall ensure that the licensee's written policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents,

(a) contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected;

(b) contains procedures and interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents, as appropriate;

(c) identifies measures and strategies to prevent abuse and neglect;

(d) identifies the manner in which allegations of abuse and neglect will be investigated, including who will undertake the investigation and who will be informed of the investigation; and

(e) identifies the training and retraining requirements for all staff, including,

(i) training on the relationship between power imbalances between staff and residents and the potential for abuse and neglect by those in a position of trust, power and responsibility for resident care, and

(ii) situations that may lead to abuse and neglect and how to avoid such situations. O. Reg. 79/10, s. 96.

Findings/Faits saillants :



1. The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents contains procedures and interventions to assist and support residents who have been abused or neglected or allegedly abused or neglected, as evidenced by:

The policy (Abuse & Neglect, dated August 2014) does not include procedures and interventions to assist or support residents who have been abused or neglected or allegedly abused or neglected.

This was confirmed by the Administrator. [s. 96. (a)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:

- 2. A description of the individuals involved in the incident, including,**
- i. names of all residents involved in the incident,**
 - ii. names of any staff members or other persons who were present at or discovered the incident, and**
 - iii. names of staff members who responded or are responding to the incident.**
- O. Reg. 79/10, s. 104 (1).**

Findings/Faits saillants :

1. The licensee has failed to ensure that the Critical Incident Report included (ii) the name of the staff involved in the incident, as evidenced by:

On a specified date, a Critical Incident Report was submitted reporting an alleged abuse. There was no mention of the name of the staff member on the Critical Incident Report.

The Administrator confirmed the staff member was not named in the Critical Incident Report. [s. 104. (1) 2.]



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