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
Jun 5, 2017	2017_589641_0011	026995-16, 028862-16, 002740-17	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 MARMORA
58 BURSTHALL STREET P.O. BOX429 MARMORA ON K0K 2M0

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

CATHI KERR (641)

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): April 11, 12, 13, 2017

This inspection was conducted in reference to three critical incidents: Log #026995 -16 and Log #002740-17 related to alleged staff to resident abuse; and Log #028862-16 related to alleged resident to resident sexual abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator (Admin), the Director of Nursing (DON), Personal Support Workers (PSW), Housekeeping staff and residents.

During the course of the inspection, the Inspector observed resident care, reviewed resident heath care records and relevant policies and procedures related to Abuse and Neglect.

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

During the course of this inspection, Non-Compliances were issued.
- **2 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 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).

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents was complied with.

An email was submitted to the Ministry of Health and Long Term Care, related to an alleged staff to resident verbal abuse that occurred on a specified date. No critical incident was submitted for this incident.

During an interview on April 13, 2017, PSW #106 indicated to Inspector #641 that on a specified date, PSW #106 was assisting PSW #102 with transferring resident #002. PSW #106 indicated that PSW #102 decided to use a different lift to transfer resident #002, for a specified clinical reason. PSW #102 didn't explain this to resident #002 so the

resident was startled when being transferred. PSW #106 indicated that when PSW #102 put the sling under resident #002, PSW #102 handled the resident very roughly and PSW #106 felt that this behaviour was excessive and not acceptable. PSW #106 indicated that she decided to wait until the next day to report the incident because she wanted to report it to management and not to the nurse in charge on the shift.

During an interview on April 13, 2017, the DON indicated to Inspector #641 that at the time of the incident, PSW #106, who was aware of the suspected abusive behaviour of PSW #102 to resident #002, had not reported the information to the charge nurse on that shift, but instead waited to inform the DON the next day.

The licensee's policy for Abuse and Neglect titled: Staff to Resident, Family to Resident, Resident to Resident, Resident and /or Family to Staff, dated February 2017 stated on page 4, that "All cases of suspected or actual abuse must be reported immediately to the DON/Administrator. In the absence of management staff, concerns should be reported immediately to the Charge Nurse, who will notify management staff on call."

PSW #106 failed to comply with the licensee's policy related to abuse and neglect of a resident, by immediately reporting the alleged abuse of resident #002 by PSW #102 to the Charge Nurse. Log #026995-16 [s. 20. (1)]

2. The licensee has failed to ensure that their policy to promote zero tolerance of abuse and neglect of residents contains an explanation of the duty under section 24 of the Act to make mandatory reports. More specifically, that any staff who had reasonable grounds to suspect that abuse of a resident by anyone, that resulted in harm or risk of harm, immediately report the suspicion to the Director.

As per LTCHA, 2007, c.8, S.24, 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.
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.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006.

The Inspector reviewed the licensee's policy for Abuse and Neglect titled: Staff to Resident, Family to Resident, Resident to Resident, Resident and /or Family to Staff, dated February 2017, which stated on page 1 "Residents, families and staff must report all situations of suspected or actual abuse to the Administrator and/or Director of Nursing (DON)," and again on page 4, that "All cases of suspected or actual abuse must be reported immediately to the DON/Administrator. In the absence of management staff, concerns should be reported immediately to the Charge Nurse, who will notify management staff on call." Nowhere in the policy does the licensee clearly indicate that any person can report a suspicion of abuse or neglect to the Director. [s. 20. (2)]

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 Director receives a report indicating the results of every investigation undertaken related to alleged, suspected or witnessed incidents of abuse or neglect.

On a specified date, PSW #106 was aware of an incident of alleged abuse related to resident #002. PSW #106 reported the incident to the Director of Nursing (DON) the following day. The DON submitted an email to the Director on the next day, indicating that alleged abuse occurred toward resident #002 by a PSW and that documentation would follow. There was no further documentation submitted to the Director indicating the results of the investigation into the alleged abuse.

The Inspector interviewed the DON on April 11, 2017. The DON indicated that she had initiated an investigation into the incident that occurred because it was reported to her as a suspected abuse of a resident. During her investigation of the incident, the DON submitted an email to the Ministry of Health and Long Term Care identifying that an alleged incident of abuse towards resident #002 by a staff member had occurred. After completing her investigation, the DON indicated that she determined that the incident didn't meet the criteria for abuse, so she did not complete a critical incident.

The licensee failed to ensure that the Director received a report indicating the results of the investigation undertaken related to the alleged abuse of resident #002 by PSW #102. Log #026995-16 [s. 23. (2)]

Issued on this 5th day of June, 2017

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

Original report signed by the inspector.