Ontario

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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 28, 2019	2019_834524_0002	015992-19, 015993-19, 017348-19, 018009-19, 018484-19, 020122-19, 021106-19	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 on Bonnie Place
15 Bonnie Place St Thomas ON N5R 5T8

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

INA REYNOLDS (524), ALI NASSER (523)

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): November 20, 21, 22, 25 and 26, 2019.

The following Critical Incidents were completed within the inspection:
Log #017348-19 / CIS #2730-000036-19 related to resident to resident abuse
Log #018009-19 / CIS #2730-000037-19 related to falls prevention and management
Log #018484-19 / CIS #2730-000038-19 related to allegations of abuse
Log #020122-19 / CIS #2730-000042-19 related to allegations of abuse
Log #021106-19 / CIS #2730-000048-19 related to falls prevention and management.

The following Follow-up intakes were completed within the inspection:
Log #015992-19 for compliance order #002 from Follow-up inspection #2019_263524_0027 related to medication
Log #015993-19 for compliance order #001 from Follow-up inspection #2019_263524_0027 related to the Head Injury Routine policy.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Resident Care Coordinator, a Registered Nurse, the Behavioural Support Ontario (BSO) Registered Practical Nurse, a Registered Practical Nurse, Personal Support Workers, a Housekeeping Aide and residents.

The inspector(s) also observed residents and the care provided to them, resident and staff interactions, observed resident rooms, reviewed clinical healthcare records including assessments and care planning interventions for identified residents, and reviewed relevant policies and procedures related to this inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
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)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 130.	CO #002	2019_263524_0027	523
O.Reg 79/10 s. 8. (1)	CO #001	2019_263524_0027	524

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	Légende 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).

Findings/Faits saillants :

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

The home submitted a Critical Incident System (CIS) report on a specific date, to the Ministry of Long-Term Care related to allegations of staff to resident emotional and verbal abuse.

The CIS indicated that on an identified date, a staff member witnessed another staff threatening and yelling back at an agitated resident. The CIS also indicated that the same staff member was heard saying a swear word while providing care to another resident.

A review of the home's policy titled "Abuse and Neglect - Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff" with reviewed date September 2018, stated under the section titled "Reporting" that: "All Cases of suspected or actual abuse must be reported immediately to the DOC/Executive Director. In the absence of management staff, concerns should be reported immediately to the Charge Nurse, who will notify management staff on call".

In an interview, Personal Support Worker (PSW) #110 said that they witnessed PSW #112 saying a swear word while providing care to resident #010. A short time later PSW #110 witnessed PSW #112 threatening and yelling at resident #009 while providing care. PSW #110 informed PSW #112 that this was inappropriate and asked them to stop and leave the room. PSW #112 left the room.

PSW #110 said that the expectation was for them to inform the charge nurse immediately of the incident. PSW #110 said at that time they were very busy and towards the end of the shift, they didn't see the nurse and they left without informing them. PSW #110 said that they understood that this was a mistake and they should have complied with the home's policy and reported the incident to the nurse immediately.

In an interview, Director of Care (DOC) #109 said that the incident occurred on a specific date, and the Resident Care Coordinator was made aware of the incident two days later. DOC #109 said that the expectation was for the staff to report the allegations to the nurse immediately and for the home's policy to be complied with. [s. 20. (1)]

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 written policy that promotedszero tolerance of abuse and neglect of residents is complied with, 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 investigation were reported to the Director.

The home submitted a Critical Incident System (CIS) report on specific date, to the Ministry of Long-Term Care related to allegations of staff to resident emotional and verbal abuse.

The CIS indicated that on an identified date, a staff member witnessed another staff threatening and yelling back at an agitated resident. The CIS also indicated that the same staff member was heard saying a swear word while providing care to another resident.

A review of the ltchomes.net on November 26, 2019, identified the CIS was not updated to show that the results of the abuse investigation were reported to the Director.

In an interview, Executive Director (ED) #100 said that the CIS was not updated with the results of the investigation. ED #100 said that changes had been made internally to ensure that the results of the abuse investigation would be reported to the Director and the CIS report updated accordingly. [s. 23. (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 to ensure that the results of the abuse investigation are reported to the Director, to be implemented voluntarily.

Issued on this 28th day of November, 2019

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

Original report signed by the inspector.