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 9, 2017	2016_291194_0037	031610-16	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 ON MCLAUGHLIN ROAD
114 McLaughlin Road LINDSAY ON K9V 6L1

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

CHANTAL LAFRENIERE (194), JENNIFER BATTEN (672)

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 28, 29, 30, December 01, and 02, 2016

A Critical incident Inspection for Log # 031610-16 was conducted for allegations of resident to resident sexual abuse.
Non compliance identified in Log # 028292-16 for allegations of staff to resident physical abuse in Inspection report # 2016_291194_0038 under LTCHA, 2007 s. 23(2) will also be issued in this report

During the course of the inspection, the inspector(s) spoke with Residents, Administrator, Interim Director of Nursing (DON), Registered Practical Nurse (RPN), Personal Support Worker (PSW) and Behavioural Ontario Support staff RPN and PSW

Review of the identified residents clinical health records and licensee's abuse policy were completed. Observation of staff to resident provision of care was completed.

The following Inspection Protocols were used during this inspection:
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. 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.

Log #031610-16 involving resident #001 and resident #002 related to alleged sexual abuse

A Critical Incident Report submitted to the Director indicated that an incident of sexual abuse between resident #001 and resident #002 was witnessed by PSW staff. The residents were separated, incident was immediately investigated.

During interview with inspector #194 and #672 the Administrator and Interim DON indicated that resident #001 had not demonstrated any inappropriate sexual behaviour before or since the incident .

During an interview with inspector #194 the Administrator indicated that the outcome of the sexual abuse investigation involving resident # 001 and resident #002 had not been reported to the Director.

Inspection # 2016_291194_0038 related to Log #028292-16 involving resident #003.

A critical incident report (CIR) was submitted to the Director for allegations of staff to resident physical abuse involving resident #003 . An investigation was initiated on when allegations of staff to resident physical abuse was reported by Substitute Decision Maker (SDM) for resident #003. The outcome of the licensee's investigation concluded that there was no evidence to support that resident #003 had been physically abused.

During an interview with inspector #194 , Administrator indicated that there had not been a report submitted to the Director with the outcome of the allegations of abuse for resident #003. [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 by ensuring that the Director is notified of the result of all abuse investigation undertaken, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies have been developed and implemented to respond to the resident #002's sexually inappropriate responsive behaviours.

Log #031610-16 involving resident #001 and resident #002 related to alleged sexual abuse

Review of the clinical health record and interview with behavioural support RPN # 109 and PSW #110 at the home indicated that there was a history of sexually inappropriate behaviour identified for resident #002. Resident #002 is cognitively impaired, wheelchair dependent and able to self propel around the unit. The progress notes for resident #002 identify sexually inappropriate behaviour with another co resident on an identified date, where interventions had been put into place to address the responsive behaviour, but had since been removed from the plan of care.

During interview with inspectors #194 and #672, BSO RPN #109 and PSW #110 identified that ongoing sexually inappropriate behaviours continued involving resident #002.

During interview with inspectors #194 and #672 , PSW #107 indicated that resident #001 had informed staff while being bathed, that resident #002 had demonstrated inappropriate sexual behaviour.

Review of the progress notes on an identified date, indicated that resident #001 had informed RPN that resident #002 had been demonstrating inappropriate sexual behaviour

On an identified date resident #001 was witnessed by PSW staff being sexually inappropriate towards resident #002.

The plan of care for resident #002 who also exhibited inappropriate sexual behviour was not developed and implemented, as described by BSO RPN #109, BSO PSW # 110 or PSW # 107 during interviews with inspectors #194 and #672 . The plan of care for resident #002 was updated to reflect the sexual inappropriate behaviour and provide intervetions and strategies to manage the behaviour, after meeting with the inspectors.
[s. 53. (4) (b)]

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 ensuring that strategies are developed and implemented for resident #002 related to the sexually inappropriate behaviours, where possible, to be implemented voluntarily.

Issued on this 10th day of January, 2017

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

Original report signed by the inspector.