Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Feb 19, 2021	2021_598570_0004	025113-20, 025520-20	Complaint

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

SAMI JAROUR (570)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): January 22, 25, 26 and 27, 2021

The following intakes were inspected:
Log #025113-20, related to an incident of missing resident.
Log #025520-20, related infection prevention and control practices in the home.

Infection prevention and control practices at the LTC home were inspected in CIS inspection #2021_598570_005 conducted concurrently with this Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Resident Care Coordinator (RCC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeepers (HSK) and a security guard.

During the course of the inspection, the inspector observed staff to residents interaction, observed IPAC practices throughout the home, reviewed health care records, reviewed relevant policies.

The following Inspection Protocols were used during this inspection:
Infection Prevention and Control
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **1 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	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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed no later than one business day after the occurrence of a resident being missing for less than three hours and who returned to the home with no injury or adverse change in condition.

A complaint was submitted to the Ministry of Long-Term Care (MLTC) related to concerns of a resident leaving the LTC home without permission.

Review of progress notes for resident #001 indicated that the resident had two incidents of elopement.

During an interview, Resident Care Coordinator (RCC) #100 indicated that resident #001 was missing for less than three hours in both incidents and that the resident had no injuries upon return to the home. The RCC indicated that the police was called for both incidents.

During an interview, the Executive Director (ED) indicated that the resident was witnessed leaving through the front door on one occasion, but the resident could not be stopped. The ED confirmed that the two incidents were not reported to the Director.

Sources: progress notes for resident #001 and interviews with RCC #100 and the Executive Director. [s. 107. (3) 1.]

Issued on this 1st day of March, 2021

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

Original report signed by the inspector.