



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

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Division de la responsabilisation et de la  
performance du système de santé  
Direction de l'amélioration de la  
performance et de la conformité

**Public Copy/Copie du public**

| <b>Report Date(s) /<br/>Date(s) du Rapport</b> | <b>Inspection No /<br/>No de l'inspection</b> | <b>Log # /<br/>Registre no</b>  | <b>Type of Inspection /<br/>Genre d'inspection</b> |
|--|---|---------------------------------|--|
| Jul 9, 2013                                    | 2013_049143_0035                              | O-000516-<br>13/O-<br>000522-13 | Critical Incident<br>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**

PAUL MILLER (143)

**Inspection Summary/Résumé de l'inspection**



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The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): June 19-21st, 2013

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing, Personal Support Workers, Registered Nurses, Registered Practical Nurses and residents.

During the course of the inspection, the inspector(s) reviewed the homes abuse policy and procedure, observed resident care and services, resident to resident interactions, reviewed resident health care records inclusive of plans of care, assessments and progress notes.

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

Findings of Non-Compliance were found during this inspection.

| <b>NON-COMPLIANCE / NON - RESPECT DES EXIGENCES</b> |                                       |
|---|---------------------------------------|
| <b>Legend</b>                                       | <b>Legendé</b>                        |
| WN – Written Notification                           | WN – Avis écrit                       |
| VPC – Voluntary Plan of Correction                  | VPC – Plan de redressement volontaire |
| DR – Director Referral                              | DR – Aiguillage au directeur          |
| CO – Compliance Order                               | CO – Ordre de conformité              |
| WAO – Work and Activity Order                       | WAO – Ordres : travaux et activités   |



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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. 6. Plan of care**

**Specifically failed to comply with the following:**

**s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).**

**Findings/Faits saillants :**



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1. On a specified date resident #3 demonstrated responsive behaviours towards staff. Resident #3 had his/her plan of care altered to include DOS charting every (Q) 30 minutes.

A review of the documentation of Q 30 minute monitoring was done for a specified period of time and indicated that documentation was not completed Q 30 minutes identifying the resident's actions or whereabouts.

On a specified date resident #3 was allegedly involved in a resident to resident (with resident #4) abuse involving inappropriate touching (of a non consensual and non sexual nature).

A review of the documentation of Q30 minute monitoring indicated that 30 minute documentation had not been completed as required.

The Licensee has failed to comply with LTCHA sec. 6(7) by not ensuring that the care set out in the plan of care was provided and documented. [s. 6. (7)]

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance**



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Specifically failed to comply with the following:

- 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).
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Findings/Faits saillants :



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1. On a specified date Caressant Care Nursing and Retirement Homes Ltd Abuse and Neglect Policy and Procedure (effective date April 2012) was reviewed and discussed with the Administrator. The Administrator confirmed with the Inspector that this Policy and Procedure identified:

Resident to Resident abuse section indicated the following:

7. The DON will advise the victim of the alleged/actual abuse regarding the possibility of laying legal charges and assist the victim in contacting the police, if necessary.

Staff to Resident Abuse section indicated the following:

8. The DON/Administrator will immediately notify the police of the alleged, suspected or witnessed incident of abuse or neglect.

Ontario Regulation 79/10 section 98. states that every licensee of a long term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

The licensee has failed to comply with the Long Term Care Homes Act section 20.(2)h by not ensuring that the policy to promote zero tolerance of abuse and neglect deals with additional matters as provided in the regulations. [s. 20. (2)]



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**WN #3: 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.

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**Findings/Faits saillants :**

1. On a specified date the inspector met with the Director of Nursing and the Administrator. Caressant Care Nursing and Retirement Homes Ltd. abuse policy and procedure effective date April 2012 was reviewed and discussed. The Administrator confirmed upon his review that the policy did not identify training requirements 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.

This policy and procedure also did not include situations that may lead to abuse and neglect and how to avoid such situations.

The licensee has failed to comply with Ontario/Regulation 79/10 section 96.(e) [s. 96. (e)]

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Issued on this 22nd day of July, 2013

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

*Pamela*