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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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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
Jul 26, 2016	2016_303563_0021	020412-16	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 WOODSTOCK NURSING HOME
81 FYFE AVENUE WOODSTOCK ON N4S 8Y2

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

MELANIE NORTHEY (563)

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): July 13, 2016

This following intake was inspected:
020412-16- Critical Incident related to suspected staff to resident abuse

During the course of the inspection, the inspector(s) spoke with the Assistant Director of Care, one Registered Nurse, one Medical Doctor, one resident and one Registered Nurse.

The inspector also made observations of residents and care provided. Relevant policies and procedures, the home's investigation notes, as well as clinical records and plans of care for the identified resident were reviewed.

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.
- **1 WN(s)**
- **1 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that that there was a written policy that promotes

zero tolerance of abuse and neglect of residents and that it was complied with.

Record review of the "Abuse & Neglect - Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff" Policy last reviewed April 2014 stated, "All cases of suspected or actual abuse must be reported immediately in written form to the DON/Administrator. In the absence of management staff, concerns should be reported immediately to the Charge Nurse, who will notify management on call" and the "Director of Nursing (DON) will immediately notify the Administrator of the initiation of an investigation. In the absence of management staff, the Charge Nurse will report initiation of an investigation to the management member on call."

Record review of the Critical Incident (CI) Report submitted to the Ministry of Health (MOH) stated there was incident of suspected abuse against resident #001.

Record review of the progress notes stated the resident accused a Personal Support Worker of abuse.

An investigation meeting was held with the Registered Nurse (RN) and the RN shared that resident #001 stated a PSW was abusive. The RN explained she did not report the allegation to the on-call manager. An investigation meeting was also held with another PSW who shared that resident #001 accused a PSW of abuse last week and it was reported to the RN. There was an investigation meeting with the accused PSW and he/she stated that the resident accused them of abuse and that they reported the accusation of abuse within 5-10 minutes to the RN. The initial allegation occurred nine days before it was reported to management.

Interview with resident #001determined that the time of day, where the incident took place and other details of the incident did not match the report given by the resident to the Assistant Director of Nursing (ADON).

The ADON explained that the PSW accused of abuse reported the accusation to the Charge Nurse who completed a progress note but did not report the abuse allegation to management. The ADON explained the reporting process starts with the person who suspects/witnesses abuse, then reported to the Charge Nurse, the Charge Nurse reports to management and management notifies the MOH and said this did not occur for the allegation of abuse of resident #001.

A telephone interview was conducted with the RN. The RN explained that resident #001

accused a PSW of abuse and said this was not unusual behaviour for this resident, but that the incident should have been reported to management as outlined in the policy. [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 that there is a written policy that promotes zero tolerance of abuse and neglect of residents and that it is complied with, to be implemented voluntarily.

Issued on this 26th day of July, 2016

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

Original report signed by the inspector.