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

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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
Mar 8, 2017	2017_508137_0001	002642-17	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 WOODSTOCK NURSING HOME
81 FYFE AVENUE WOODSTOCK ON N4S 8Y2

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

MARIAN MACDONALD (137)

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): October 28, 2016 until March 7, 2017

During this Complaint Inspection, several Critical Incident System (CIS) Inspections were completed, including 004840-16, 008948-16, 015639-16, 017131-16, 021944-16, 027293-16, 027733-16, 029609-16, 031470-16, 033028-16, 033029-16, 035063-16, 000464-17, 000590-17, 000857-17, 001129-17, 001413-17, 001869-17, related to alleged resident to resident abuse, alleged staff to resident abuse, improper transferring techniques, medication incidents, continence care assessments, plan of care and not reporting to the Director.
A compliance order was issued on November 25, 2015, reissued on October 20, 2016 with a compliance date of October 31, 2016, and reissued as a compliance order on January 25, 2017 with a compliance date of January 27, 2017, related to not reporting to the Director.

During the course of the inspection, the inspector(s) spoke with Administrator, Acting Director of Nursing, Corporate Representative, one Registered Nurse, five Personal Support Workers and one Housekeeper.

The Inspector also observed provision of resident care, staff to resident interactions, reviewed resident clinical records, employee personnel files and relevant policies and procedures.

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)**
- **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	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. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

"Verbal abuse" means, any form of verbal communication of a threatening or intimidating nature or any form of communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

An Infoline complaint, letters of complaint and email correspondence were received by Central Intake Assessment Triage Team (CIATT) from a Personal Support Worker (PSW), related to an incident of verbal abuse by another PSW towards an identified resident.
The documentation showed the Director of Nursing and a Corporate Representative were aware of the suspected verbal abuse.

During provision of care, an identified resident scratched a PSW and then used foul language while speaking to the resident, as well as when they told another PSW to get the resident ready.

In an interview with the Corporate Representative, they stated of being aware of the suspected verbal abuse and that the suspected abuse was not immediately reported to the Director.

In an interview with the Administrator, they said there was no documented evidence that an investigation or follow up occurred related to the incident and the suspicion of abuse should have been immediately reported to the Director.

In reviewing the Ministry of Health and Long Term Care Critical Incident System, there were no critical incidents reported related to suspicion of verbal abuse towards an identified resident.

The licensee has failed to report a suspicion of verbal abuse immediately to the Director, related to an identified resident.

The severity of this non-compliance was a level two, potential for actual harm/risk and the scope was isolated. The home has a history of non-compliance in this subsection of the legislation; a compliance order was issued on November 25, 2015, reissued on October 20, 2016 with a compliance date of October 31, 2016, and reissued as a compliance order on January 25, 2017, with a compliance date of January 27, 2017. [s. 24. (1)]

Issued on this 9th day of March, 2017

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

Original report signed by the inspector.