

**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**London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300Bureau régional de services de
London
130, avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300**Public Copy/Copie du rapport public**

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 23, 2021	2021_722630_0014	024836-20, 024946-20, 002700-21, 003397-21, 003415-21, 003565-21, 004518-21	Complaint

Licensee/Titulaire de permisCaressant-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**

AMIE GIBBS-WARD (630), CHRISTINA LEGOUFFE (730)

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): March 16, 17, 18, 19 and 22, 2021.

The following Complaint intakes were completed within this inspection:

Log # 024836-20 related to falls prevention and management, resident bill of rights and physiotherapy care;

Log # 003565-21 and # 002700-21 related to allegations of staff to resident physical and emotional abuse;

Log # 003397-21 related to nutrition care.

The following Critical Incident (CI) intakes were completed within this inspection:

Log # 024946-20 / CI 2636-000031-20 related to falls prevention and management;

Log # 003415-21 / CI 2636-000008-21 related to allegations of staff to resident neglect;

Log # 004518-21 / CI 2636-000012-21 related to allegations of staff to resident physical abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Assistant Director of Care (ADOC), the Environmental Services Manager (ESM), a Resident Care Coordinator (RCC), the Registered Dietitian (RD), the Physiotherapist (PT), the Behavioural Supports Ontario Personal Support Worker (BSO PSW), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Housekeepers, Personal Support Workers (PSWs) and residents.

The inspectors also observed resident rooms and common areas, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed Critical Incident System (CIS) reports, and reviewed relevant policies and procedures of the home.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy

Falls Prevention

Nutrition and Hydration

Prevention of Abuse, Neglect and Retaliation

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

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	
<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3.
Residents' Bill of Rights**

Specifically failed to comply with the following:

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following
rights of residents are fully respected and promoted:**

**1. Every resident has the right to be treated with courtesy and respect and in a way
that fully recognizes the resident's individuality and respects the resident's
dignity. 2007, c. 8, s. 3 (1).**

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident's right to be treated with courtesy and respect, was respected.

The Ministry of Long-Term Care (MLTC) received an anonymous complaint related to concerns regarding the care staff provided to a resident.

The resident's plan of care and staff interviews indicated that the resident required specific interventions and staff approach for their care.

Interviews with staff members identified that they had concerns with how this resident has been treated by another staff member when care was being provided during a specific shift.

There was increased risk to the resident related to not being treated with courtesy and respect.

Sources: The resident's plan of care and interviews with staff and the complainant. [s. 3. (1) 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 the rights of residents are fully respected and promoted including the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity, to be implemented voluntarily.

Issued on this 23rd day of March, 2021

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

Original report signed by the inspector.