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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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
Aug 12, 2021	2021_607523_0019	007639-21, 008677-21, 009761-21, 011123-21, 011672-21, 011798-21	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

ALI NASSER (523)

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): August 3, 4, 5, 6 and 9, 2021.

This inspection was completed with inspectors Angela Finlay #705243 and Catherine Ochnik #704957.

This inspection was completed for the following Critical Incident Intakes:
Log #011798-21, related to unexpected death of a resident.
Log #011672-21, related to a resident's fall.
Log #011123-21, related to hot air temperatures.
Log #009761-21, related to alleged staff to resident abuse.
Log #008677-21, related to alleged staff to resident abuse.
Log #007639-21, related to resident to resident abuse.

This inspection was completed concurrently with inspection #2021_607523_0020, complaint Intake #009531-21, related to isolation concerns.

During the course of the inspection, the inspector(s) spoke with Administrator, Assistant Director of Care, Environmental Services Manager, two Housekeeping staff members, six Personal Support Workers, a Resident Care Coordinator, a RAI Coordinator, five Registered staff members and six residents.

The inspector(s) also toured the home, observed residents and care provided to them, reviewed clinical records, incident reports, investigation notes and reviewed specific policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

- **1 WN(s)**
- **0 VPC(s)**
- **1 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 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 the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

The home submitted a Critical Incident System (CIS) report on a specific date related to allegation of staff to resident abuse. The CIS showed staff did not report the allegations of abuse immediately.

A review of the home's policy title Zero Tolerance of Abuse and Neglect, Policy No. ADMIN-001, showed "Staff must immediately report suspected or witnessed incidents of abuse of a resident by anyone, neglect of a resident by the licensee, a staff member (or affiliate) of the home, and anything else provided for in the regulations. Staff must immediately inform the Executive Director/designate. if the situation happens after regular business hours, immediately inform the Registered Nurse in Charge. The RN in charge will notify the manager on-call of the situation, Do not leave voice messages you must speak directly to a person".

In an interview the Administrator said the specific RN who was made aware of the allegations did not immediately report the allegations to the on-call manager. The Administrator said the expectation was for the RN to report the allegations immediately to the manager or on call manager.

Administrator said education was provided to staff about the policy regarding immediate reporting.

Sources: CIS, staff interviews.

B) The home submitted a Critical Incident System (CIS) report on a specific date related to allegations of staff to resident abuse. The CIS showed that the staff reported the allegations the next day.

A review of the home's policy title Zero Tolerance of Abuse and Neglect, Policy No. ADMIN-001, showed "Staff must immediately report suspected or witnessed incidents of abuse of a resident by anyone, neglect of a resident by the licensee, a staff member (or affiliate) of the home, and anything else provided for in the regulations. Staff must immediately inform the Executive Director/designate. if the situation happens after regular business hours, immediately inform the Registered Nurse in Charge. The RN in charge will notify the manager on-call of the situation, Do not leave voice messages you must speak directly to a person".

A review of the internal investigation notes showed that the resident shared allegations of abuse with one specific PSW, that PSW then shared the information with different PSWs, all of them did not immediately report the allegations to the nurse.

In an interview the ADOC said the expectation was for the staff to immediately report any allegations of abuse to the nurse, the staff did not comply with the home's policy by not reporting the allegations immediately.

Sources: CIS, record review, staff interviews. [s. 20. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 13th day of August, 2021

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	ALI NASSER (523)
Inspection No. / No de l'inspection :	2021_607523_0019
Log No. / No de registre :	007639-21, 008677-21, 009761-21, 011123-21, 011672-21, 011798-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Aug 12, 2021
Licensee / Titulaire de permis :	Caressant-Care Nursing and Retirement Homes Limited 264 Norwich Avenue, Woodstock, ON, N4S-3V9
LTC Home / Foyer de SLD :	Caressant Care Woodstock Nursing Home 81 Fyfe Avenue, Woodstock, ON, N4S-8Y2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Natalie Aikens

To Caressant-Care Nursing and Retirement Homes Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s. 20 (1) of the LTCHA.
Specifically, the licensee must:

a) Ensure the prevention of abuse and neglect policy is complied with related to staff immediately reporting allegations of abuse and neglect.

b) Ensure In-Person training is provided to all staff regarding mandatory reporting requirements and each staff member's role and responsibilities related to reporting allegations of abuse and neglect.

c) The home must keep a written record of the training including:
- the content of the materials used to complete the training;
- the dates of each training session with an attendance list, including printed names and
signatures of all attendees, and;
- the name of the staff member providing the training.

Grounds / Motifs :

1. The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

The home submitted a Critical Incident System (CIS) report on a specific date related to allegation of staff to resident abuse. The CIS showed staff did not report the allegations of abuse immediately.

A review of the home's policy title Zero Tolerance of Abuse and Neglect, Policy No. ADMIN-001, showed "Staff must immediately report suspected or witnessed incidents of abuse of a resident by anyone, neglect of a resident by the licensee, a staff member (or affiliate) of the home, and anything else provided for in the regulations. Staff must immediately inform the Executive Director/designate. if the situation happens after regular business hours, immediately inform the Registered Nurse in Charge. The RN in charge will notify the manager on-call of the situation, Do not leave voice messages you must speak directly to a person".

In an interview the Administrator said the specific RN who was made aware of the allegations did not immediately report the allegations to the on-call manager. The Administrator said the expectation was for the RN to report the allegations immediately to the manager or on call manager.

Administrator said education was provided to staff about the policy regarding immediate reporting.

Sources: CIS, staff interviews.

B) The home submitted a Critical Incident System (CIS) report on a specific date related to allegations of staff to resident abuse. The CIS showed that the staff reported the allegations the next day.

A review of the home's policy title Zero Tolerance of Abuse and Neglect, Policy No. ADMIN-001, showed "Staff must immediately report suspected or witnessed incidents of abuse of a resident by anyone, neglect of a resident by the licensee, a staff member (or affiliate) of the home, and anything else provided for in the regulations. Staff must immediately inform the Executive Director/designate. if the situation happens after regular business hours, immediately inform the Registered Nurse in Charge. The RN in charge will notify the manager on-call of the situation, Do not leave voice messages you must speak directly to a person".

A review of the internal investigation notes showed that the resident shared allegations of abuse with one specific PSW, that PSW then shared the information with different PSWs, all of them did not immediately report the allegations to the nurse.

In an interview the ADOC said the expectation was for the staff to immediately report any allegations of abuse to the nurse, the staff did not comply with the home's policy by not reporting the allegations immediately.

Sources: CIS, record review, staff interviews.

An order was made by taking the following factors into account:
Severity: There was a risk to residents by not immediately reporting allegations of abuse.
Scope: This non compliance affected two out of three residents.
Compliance History: this non compliance was issued previously twice in the home as a Written Notification, Voluntary Plan of Correction and Compliance Order.
(523)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 29, 2021

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 12th day of August, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Ali Nasser

Service Area Office /
Bureau régional de services : London Service Area Office