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 # / No de registre	Type of Inspection / Genre d'inspection
Jul 17, 2018	2018_605213_0011	001789-16, 018659-16, 029510-16, 000166-17, 006084-17, 019790-17, 016023-18, 016722-18, 016723-18	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 Courtland
4850 Hwy #59 P.O. Box 279 Courtland ON N0J 1E0

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

RHONDA KUKOLY (213), NATALIE MORONEY (610)

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 9, 10, 11, 12, 2018

This inspection was completed related to nine critical incidents including:
Log #001789-16, Critical Incident #2826-000003-16, related to alleged staff to resident physical and verbal abuse.
Log #018659-16, Critical Incident #2826-000018-16, related to alleged staff to resident verbal abuse.
Log #029510-16, Critical Incident #2826-000024-16, related to resident to resident physical abuse.
Log #000166-17, Critical Incident #2826-000001-17, related to alleged staff to resident physical abuse.
Log #006084-17, Critical Incident #2826-000012-17, related to alleged staff to resident physical abuse.
Log #019790-17, Critical Incident #2826-000025-17, related to alleged staff to resident verbal abuse.
Log #016023-18, Critical Incident #2826-000013-18, related to falls.
Log #016722-18, Critical Incident #2826-000011-18, related to alleged staff to resident verbal abuse.
Log #016723-18, Critical Incident #2826-000012-18, related to falls.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing, a Physician, the Resident Assessment Instrument Coordinator, a Registered Nurse, a Registered Practical Nurse, Personal Support Workers and residents.

The Inspectors also made observations and reviewed health records, internal investigation records, policies, education records and other relevant documentation.

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

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 :

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

Section 2 (1) of the Ontario Regulation 79/10 defines "verbal abuse" as any form of verbal communication of a threatening or intimidating nature or any form of verbal 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.

The home reported a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) on an identified date related to an alleged incident of staff to resident abuse that occurred two days previous to the report. It was reported in the CIS that Personal Support Worker (PSW) #112 verbally reported to the Director of Nursing (DON) #102 on the date the incident occurred, that while they and PSW #113 were providing care to resident #010 that day, the resident was confused and was asking why the care was happening. PSW #112 reported that PSW #113 scolded the resident using derogatory language.

In an interview with the DON #102 on July 12, 2018, the DON said that PSW #112 did report the incident of alleged verbal abuse of resident #010 by PSW #113 the day it occurred. The DON said that they were busy at the time and asked PSW #112 to document their report. The DON said that PSW #112 provided a written report of the incident the following day, but they did not immediately act on the verbal or the written report of alleged abuse.

In an interview with the Administrator #101 on July 12, 2018, the Administrator said that they received a note in their mailbox two days after the incident occurred, detailing the incident, from the staff who witnessed it, and questioned why they were just hearing about it two days later. Upon receiving the written report, the Administrator reported the incident of alleged staff to resident verbal abuse to the MOHLTC and initiated an immediate investigation. During the Administrator‘s investigation upon receiving this information, PSW #112 told the Administrator that they reported it the day it occurred, to the DON #102. In addition, the DON advised the Administrator that they were told about the incident the day it occurred and that the DON told PSW #112 to write it down, but then got busy and forgot about it, and didn't immediately follow up or report the incident to the MOHLTC.

The "Caressant Care Nursing and Retirement Homes Ltd. Abuse & Neglect - Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff" policy and procedure, dated July 2018, was reviewed and stated in part:
Reporting:
1. All cases of suspected or actual abuse must be reported immediately to the Director of Care/Executive Director. In the absence of management staff, concerns should be reported immediately to the Charge Nurse, who will notify the management on call.
2. After receiving a notice of the abuse, the Director of Care/Manager on call will immediately notify the Executive Director and the initiation of an investigation.
6. The Executive Director/Director of Care who has reasonable grounds to suspect that any of the following has occurred or may occur must immediately report that suspicion and the information upon which the suspicion is based to the Director.
a) Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to a resident.
b) Abuse of a resident by anyone, or neglect of a resident by the home or its staff, that resulted in harm or risk of harm to a resident.

The Director of Nursing #102 received a report of alleged verbal abuse of resident #010

by PSW #113 and failed to immediately report the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

Issued on this 17th day of July, 2018

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

Original report signed by the inspector.