Inspection Report under the *Long-Term Care Homes Act, 2007*

Rapport d'inspection prévue le *Loi de 2007 les foyers de soins de longue durée*

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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347, rue Preston, 4iém étage
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☐ **Licensee Copy/Copie du Titulaire** X **Public Copy/Copie Public**

Date(s) of inspection/Date de l'inspection	**Inspection No/ d'inspection**	**Type of Inspection/Genre d'inspection**
February 3, 2011	2011-117-1160-03Feb095534	Complaint Log # O-000143

Licensee/Titulaire
Caressant Care Nursing and Retirement Homes Limited
264 Norwich Avenue
Woodstock, ON N4S 3V9
Fax: 519-539-9601

Long-Term Care Home/Foyer de soins de longue durée
Caressant Care Bourget
2279 Laval Street
PO. Box 99
Bourget, ON K0J 1E0

Name of Inspector(s)/Nom de l'inspecteur(s)
Lyne Duchesne #117

Inspection Summary/Sommaire d'inspection

The purpose of this inspection was to conduct a complaint inspection regarding the care and services of a resident.

During the course of the inspection, the inspector spoke with the home's the Director of Care, to a Registered Nurse and to a Personal Support Worker.

During the course of the inspection, the inspector reviewed the health care record two residents.

The following Inspection Protocol was used during this inspection:

- Responsive Behaviours

Findings of Non-Compliance were found during this inspection. The following action was taken:

3 WN
1 VPC
2 CO: CO # 001, #002

NON- COMPLIANCE / (Non-respectés)

Definitions/Définitions

WN – Written Notifications/Avis écrit
VPC – Voluntary Plan of Correction/Plan de redressement volontaire
DR – Director Referral/Régisseur envoyé
CO – Compliance Order/Ordres de conformité
WAO – Work and Activity Order/Ordres: travaux et activités

The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.

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.)

Le suivant constituer un avis d'écrit de l'exigence prévue le paragraphe 1 de section 152 de les foyers de soins de longue durée.

Non-respect avec les exigences sur le *Loi de 2007 les foyers de soins de longue durée* à trouvé. (Une exigence dans le loi comprend les exigences contenues dans les points énumérés dans la définition de "exigence prévue par la présente loi" au paragraphe 2(1) de la loi.

WN #1: The Licensee has failed to comply with the LTCHA 2007, S.O. 2007, c. 8, 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:

(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.

Findings:

- A resident who suffers from dementia is identified as being physically and verbally aggressive with other residents and staff.

- The licensee did not immediately notify MOHLTC of four incidents of resident to resident abuse that occurred in December 2010 and on January 7 and 9, 2011, as per LTCHA 2007, section 24 (1)(2).

- The home's Director of Care stated on February 3, 2011 that she had not received full training on MOHLTC Critical Incident Systems, reporting mechanisms and reporting requirements.

- A Personal Support Worker states that in early December 2010 she witnessed the identified resident hit another resident in the throat. The Personal Support Worker states that the other resident sustained a bruise to the side of his/her neck. The Personal Support Worker states that she reported the incident to the unit's Registered Nurse. There is no documentation regarding this incident in the identified resident's health care record. The injured resident's health care record documents that on December 2, 2010 that a Personal Support Worker reported to the home's Director of Care that the injured resident had been punched in the face the previous Saturday.

- On January 7, 2011, an identified resident was physically abusive towards two residents. Both incidents occurred within minutes of each other. The first resident was hit by identified resident and sustained a bruise and scratch to his / her nose. The second resident was hit by the identified resident and sustained pain to his/her wrist and face.

- On January 9, 2011, the identified resident was physically abusive towards another resident. The other resident was hit in the head and arms. He/she was assessed and complained of pain and headache.

Compliance Order #001 was faxed to the licensee – See Order Report

Inspector ID #:	117

WN #2: The Licensee has failed to comply with O.Reg. 79/10, s 98 Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Findings:

- The licensee did not report of four incidents of resident to resident abuse that occurred in December 2010 and on January 7 and 9, 2011 to local police force.

- The home's Director of Care stated on February 3, 2011 that she had not received full training on MOHLTC Critical Incident Systems, reporting mechanisms and reporting requirements.

- A Personal Support Worker states that in early December 2010 she witnessed the identified resident hit another resident in the throat. The Personal Support Worker states that the other resident sustained a bruise to the side of his/her neck. The Personal Support Worker states that she reported the incident to the unit's Registered Nurse. There is no documentation regarding this incident in the identified resident's health care record. The injured resident's health care record documents that on December 2, 2010 that a Personal Support Worker reported to the home's Director of Care that the injured resident had been punched in the face the previous Saturday.

- On January 7, 2011, an identified resident was physically abusive towards two residents. Both incidents occurred within minutes of each other. The first resident was hit by identified resident and sustained a bruise and scratch to his / her nose. The second resident was hit by the identified resident and sustained pain to his/her wrist and face.

- On January 9, 2011, the identified resident was physically abusive towards another resident. The other resident was hit in the head and arms. He/she was assessed and complained of pain and headache.

Compliance Order #002 was faxed to the licensee – See Order Report

Inspector ID #:	117

WN #3: The Licensee has failed to comply with the LTCHA 2007, S.O. 2007, c.8, s.6 (11) When a resident is reassessed and the plan of care reviewed and revised,

(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care.

Findings:

- A resident who suffers from dementia is identified as being physically and verbally aggressive with other residents and staff.
- A Personal Support Worker states that in early December 2010 she witnessed the identified resident hit another resident in the throat. The Personal Support Worker states that the other resident sustained a bruise to the side of his / her neck. The Personal Support Worker states that she reported the incident to the unit's Registered Nurse. No interventions implemented to address the identified resident's behaviours.

Inspector ID #:	117

Additional Required Actions:

VPC #1 - 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 regarding the need to ensure that actions t are taken to revise the identified resident's plan of care to respond to the needs of the resident, including assessments, reassessments and interventions, to be implemented voluntarily.

Signature of Licensee or Representative of Licensee **Signature du Titulaire du représentant désigné**		**Signature of Health System Accountability and Performance Division representative/Signature du (de la) représentant(e) de la Division de la responsabilisation et de la performance du système de santé.**
Title:	**Date:**	**Date of Report:** (if different from date(s) of inspection). February 14, 2011

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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

	☐ Licensee Copy/Copie du Titulaire X Public Copy/Copie Public		
Name of Inspector:	Lyne Duchesne	**Inspector ID #**	117
Log #:	O-000143		
Inspection Report #:	2011_117_1160_03Feb095534		
Type of Inspection:	Complaint		
Date of Inspection:	February 3, 2011		
Licensee:	Caressant Care Nursing and Retirement Homes Limited 264 Norwich Avenue Woodstock, ON N4S 3V9 Fax: 519-539-9601		
LTC Home:	Caressant Care Bourget 2279 Laval Street PO. Box 99 Bourget, ON K0J 1E0 Fax: 613-487-3464		
Name of Administrator:	Tanja Koch		

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:

Order #:	001	**Order Type:**	Compliance Order, Section 153 (1) (b)

Pursuant to: The Licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, 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:

(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.

Order: The licensee shall prepare, submit and implement a plan for achieving compliance to meet the requirement that a person who has reasonable grounds to suspect that any abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm, shall immediately report the suspicion and the information upon which it is based to the Director.

The plan must be submitted to Lyne Duchesne, Long Term Care Home's Inspector, Ottawa SAO by February 25, 2011 via fax # (613) 569-9670

Grounds:

- A resident who suffers from dementia is identified as being physically and verbally aggressive with other residents and staff.
- The licensee did not immediately notify MOHLTC of four incidents of resident to resident abuse that occurred in December 2010 and on January 7 and 9, 2011, as per LTCHA 2007, section 24 (1)(2).
- The home's Director of Care stated on February 3, 2011 that she had not received full training on MOHLTC Critical Incident Systems, reporting mechanisms and reporting requirements.
- A Personal Support Worker states that in early December 2010 she witnessed the identified resident hit another resident in the throat. The Personal Support Worker states that the other resident sustained a bruise to the side of his/her neck. The Personal Support Worker states that she reported the incident to the unit's Registered Nurse. There is no documentation regarding this incident in the identified resident's health care record. The injured resident's health care record documents that on December 2, 2010 that a Personal Support Worker reported to the home's Director of Care that the injured resident had been punched in the face the previous Saturday.
- On January 7, 2011, an identified resident was physically abusive towards two residents. Both incidents occurred within minutes of each other. The first resident was hit by identified resident and sustained a bruise and scratch to his / her nose. The second resident was hit by the identified resident and sustained pain to his/her wrist and face.
- On January 9, 2011, the identified resident was physically abusive towards another resident. The other resident was hit in the head and arms. He/she was assessed and complained of pain and headache.

This order must be complied with by:	February 25, 2011		
Order #:	002	**Order Type:**	Compliance Order, Section 153 (1) (b)

Pursuant to: The Licensee has failed to comply with O.Reg. 79/10, s 98 Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

Order: The licensee shall prepare, submit and implement a plan for achieving compliance to meet the requirement that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

The plan must be submitted to Lyne Duchesne, Long Term Care Home's Inspector, Ottawa SAO by February 25, 2011 via fax # (613) 569-9670

Grounds:

- The licensee did not report of four incidents of resident to resident abuse that occurred in December 2010 and on January 7 and 9, 2011 to local police force.
- The home's Director of Care stated on February 3, 2011 that she had not received full training on MOHLTC Critical Incident Systems, reporting mechanisms and reporting requirements.
- A Personal Support Worker states that in early December 2010 she witnessed the identified resident hit another resident in the throat. The Personal Support Worker states that the other resident sustained a bruise to the side of his/her neck. The Personal Support Worker states that she reported the incident to the unit's Registered Nurse. There is no documentation regarding this incident in the identified resident's health care record. The injured resident's health care record documents that on December 2, 2010 that a Personal Support Worker reported to the home's Director of Care that the injured resident had been punched in the face the previous Saturday.
- On January 7, 2011, an identified resident was physically abusive towards two residents. Both incidents occurred within minutes of each other. The first resident was hit by identified resident and sustained a bruise and scratch to his / her nose. The second resident was hit by the identified resident and sustained pain to his/her wrist and face.
- On January 9, 2011, the identified resident was physically abusive towards another resident. The other resident was hit in the head and arms. He/she was assessed and complained of pain and headache.

This order must be complied with by:	February 25, 2011

Ministry of Health and Long-Term Care
Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Ministère de la Santé et des Soins de longue durée
Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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 service for the Licensee.

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

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
55 St. Clair Ave. West
Suite 800, 8th floor
Toronto, ON M4V 2Y2
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 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 group of members not connected with the Ministry. They are appointed by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, with 28 days of being served with the notice of the Director's decision, mail or deliver a written notice of appeal to both:

Health Services Appeal and Review Board   **and the**
Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON
M5S 2T5

Director
c/o Appeals Clerk
Performance Improvement and Compliance Branch
55 St. Claire Avenue, West
Suite 800, 8th Floor
Toronto, ON M4V 2Y2

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.

Issued on this 15th day of February, 2011.	
Signature of Inspector:	
Name of Inspector:	Lyne Duchesne
Service Area Office:	Ottawa