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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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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
Feb 1, 2016	2016_289550_0007	026847-15, 016734-15	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 BOURGET
2279 Laval Street P.O. Box 99 Bourget ON K0A 1E0

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

JOANNE HENRIE (550)

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): January 22, 25, 26, 27 and 28, 2016

The inspection also included one critical incident under Log 016734-15.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the RAI/MDS Coordinator, Registered Nurses (RN),Personal Support Workers (PSW), the Behaviour Supports Ontario (BSO) PSW, and resident(s).

In addition, the inspector reviewed resident health care records, policies related to responsive behaviours, a complaint and a critical incident report. Inspector also observed care and services and staff and resident interaction.

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **0 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6.	WN	2015_198117_0011	550
LTCHA, 2007 S.O. 2007, c.8 s. 6.	WN	2015_289550_0009	550

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #003's plan of care is based on an assessment of the resident and the resident's needs and preferences.

Resident #003 is identified has having many responsive behaviours including a fear of staff members of the opposite sex and making false accusations towards specific residents and staff members.

During an interview, resident #003 indicated to Inspector #550 he/she does not want staff members of the opposite sex to care for him/her expressing a fear of the opposite sex due to past abuse. Resident #003 indicated he/she only wants same sex staff to enter his/her room and that this was not always respected.

Inspector reviewed resident #003's actual care plan and was unable to find documentation of the resident's need and preference to have same sex PSW's caring for him/her.

During an interview, BSO staff #S100 and PSW #S102 indicated to Inspector #550 the resident often speaks of being abused by people of the opposite sex and he/she also has a tendency to falsely accuse people of the opposite sex of abuse. The BSO staff further indicated she had discussed with the new DOC the possibility of having only same sex staff care for the resident but the DOC indicated to her she would not accommodate this request at this time.

The DOC indicated to the inspector she was not aware that the resident had requested to have only same sex PSWs to care for him/her. She further indicated not being aware of the resident's fear of people of the opposite sex, that the resident always indicated to her he/she was abused by same sex people. The DOC indicated she was made aware of this request by the BSO the day before and had been reluctant in implementing it because the resident is known to have manipulative behaviours and the DOC was concerned that by limiting who could provide care would increase the resident's

behaviours.

During an interview, the Administrator indicated to the inspector being aware that the resident only wants same sex PSWs to care for him/her and he thought this was indicated in the resident's plan of care. He stated that staffs are aware of this request.

As such, the resident's plan of care was not based on an assessment of resident #003 and his/her needs and preferences of being cared for only by same sex PSWs. [s. 6. (2)]

WN #2: 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 the person who had reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was 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 risk of harm.

A critical incident report was submitted to the Director on a specific date in July 2015 reporting an incident of suspected resident to resident sexual abuse. It was reported that on another specific date in July 2015 resident #003 indicated to the home' s Administrator that on a specific date in June 2015 a same sex resident opened the privacy curtains in his/her room while the resident was naked and washing himself/herself in the morning. During the evening that same day, a resident from the opposite sex entered resident #003's room, opened the privacy curtains while the resident was washing himself/herself and getting ready for bed. The resident from the opposite sex approached resident #003 and touched a specific body part. Resident #003 told this resident to stop which he/she did and left the room.

The Administrator indicated to Inspector #550 that he did not immediately report this incident of resident to resident suspected sexual abuse to the Director because he started an investigation immediately and he forgot to report it. He reported the incident the following day. He further indicated being aware that the incident should have been reported immediately as indicated in the LTCH Act.

As such, the Director was not immediately informed of this incident of suspected resident sexual abuse. [s. 24. (1)]

Issued on this 1st day of February, 2016

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

Original report signed by the inspector.