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 # / Registre no	Type of Inspection / Genre d'inspection
Sep 13, 2016	2016_289550_0030	013113-16, 020563-16	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): August 8 and 9, 2016

This complaint inspection is related to one complaint and one critical incidents the home submitted related to allegations of abuse to two residents.

During the course of the inspection, the inspector(s) spoke with During the course of the inspection, the inspector spoke with the home's Administrator, the Director of Care (DOC), the Food and Nutrition Manager, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

In addition, the inspectors reviewed resident health care records and policies related to complaints. The inspector observed resident care and services and staff and resident interaction.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Dining Observation
Medication
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

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)**

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 O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the daily and weekly menus are communicated to residents.

This inspection is related to Log #013113-16.

On August 09, 2016, at lunchtime, PSW #S100 showed two different meal choices to resident #002 and indicated that there was meatloaf or beef for lunch. The posted menu indicated for that day:

Tuesday week 2
Italian baked fish or honey mustard chicken

The inspector reviewed the week at a glance menu and was unable to find this menu for lunch on any of the three week menu. The Food Nutrition Manager (FNM) indicated to the inspector that the lunch menu was lamb curry, fluffy rice, peas or meatloaf, mashed potatoes, herbed green beans, cheesecake or grapes and that the dietary aid from the previous evening shift must have mixed up the winter menu with the summer menu. The inspector was still unable to find this menu on any of the three week at a glance menu. The FNM indicated that on the week at a glance menu, the menu is reversed. For lunch they will serve what is indicated on the week at a glance menu as the supper menu and for supper they will serve what is indicated as the lunch menu as they now offer the heavier meal at lunchtime. She indicated she was not the one who prepared the week at a glance menu as she has been working in this home for approximately 2 weeks.

As evidenced above, the daily and weekly menus were not communicated to the residents. [s. 73. (1) 1.]

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, a response was made to the person who made the complaint, indicating:
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief.

This inspection is related to Log #020563-16.

In the summer an identified date, resident #001 informed the home's Corporate Dietician during a conversation that a staff member swore and talked in a bad way to him/her and other residents. Resident #001 also complained that another employee of a specific ethnicity rolled her eyes and turned away whenever the resident asked her questions. The home immediately investigated the complaint and were unable to determine that any abuse had occurred.

During an interview, the Administrator indicated to the inspector that he had not communicated to resident #001 the results of the home' investigation following the verbal complaint of alleged verbal abuse. He indicated that he forgot to do so.

As such, the licensee has not responded to resident #001 following the complaint of alleged verbal abuse. [s. 101. (1) 3.]

Issued on this 13th day of September, 2016

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

Original report signed by the inspector.