Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 23, 2019	2019_583117_0042	008695-19	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 Bourget
2279 Laval Street P.O. Box 99 Bourget ON K0A 1E0

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

LYNE DUCHESNE (117)

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): September 17, 18 and 19, 2019

This inspection relates to a critical incident inspection log # 008695-19: CIS # 1160-000009-19 related to an alleged incident of staff to resident abuse / neglect.

During the course of the inspection, the inspector(s) spoke with the home's administrator, acting Director of Care (ADOC), several Registered Nurses (RNs), a Registered Practical Nurse (RPN), the home's RAI Coordinator, several Personal Support Workers (PSWs) as well as to several residents.

During the course of this inspection, the inspector reviewed several residents health care records, observed the provision of resident care and services, observed the use and application of mobility devices and personal assistance services devices (PASD), reviewed an internal investigation report, reviewed staff education and training on Abuse and Neglect, reviewed the licensee's policies "Abuse & Neglect - Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff", reviewed September 2018 and "Safety Plan - Resident", relate to alternative approaches to the use of restraints, reviewed May 2018

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

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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	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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents are free from neglect by the licensee or staff in the home.

As per O. Reg. 79/10, s. 5, for the purposes of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

On a specified day in 2019, the home's administrator submitted a critical incident report CIS # 1160-000009-19 which reported an incident of staff to resident neglect.

Resident #001 was identified as person who was at high risk for falls and some responsive behaviours which included an active need to ambulate with the aid of walker unit hallways to alleviate a medical condition. The resident's plan of care identified the use of a wheelchair with a lap belt, to help with rest periods and prevent falls. The lap belt, which the resident could undo, was identified as a personal assistance service device (PASD).

On a specified day in 2019, resident #001 presented with increased agitation and ambulating behaviours in and out of their room. RN #104 gave directions to PSW #107 to sit resident #001 in wheelchair by the nursing station to help decrease and monitor the resident's responsive behaviours. This was actioned by PSW #107 who seated resident #001 in a wheelchair with a lap belt and positioned the resident by the nursing station.

At a specified time of day, PSW #105, #106 and #108 arrived on the unit for the start of their shift. They noted that the resident was seated in the hallway, in a tilted wheelchair with little clothing on. The resident was agitated, trying to sit in a more upright position in the wheelchair. PSW #105 attended to the resident and noted that a towel had been wrapped around the lap belt. PSW #105 requested PSW #106's assistance with the provision of the resident's care. Both PSW #105 and #106 reported the incident to the home's Administrator.

The home's administrator and food nutrition manager reviewed the home's security footage as they suspected possible neglect of the resident. The security footage showed that the resident had been brought by PSW #107, in a tilted wheelchair to the nursing station at a specified time. The resident was wearing little clothing at that time. At approximately 15 minutes later, the resident was noted to be agitated and trying to get up out of the wheelchair. PSW #107 was noted to apply a towel to the lap belt.

The video showed RN #104 on the unit approximately 15 minutes afterwards, staying for a few minutes and then leaving to go to another unit. There was no observed interaction between RN #104 and resident #001 at that time.

Approximately 1.5 hours later, the resident was found by PSWs #105 and #106 seated by the nursing station, in the tilted wheelchair, agitated, trying to get in more upright position and with a towel wrapped around the wheelchair lap belt. The resident's walker was later found to be in another resident's room.

As such, a specified day in 2019, PSW #107 failed to provide care and ensure the safety and well being of resident #001 when the resident was left in a tilted wheelchair, with a prohibited device (towel) limiting movement (see WN #02), with little clothing in a state of agitation for a period of approximately 2 hours. [s. 19. (1)]

Additional Required Actions:

VPC - 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 to ensure that a long-term home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 112. Prohibited devices that limit movement
For the purposes of section 35 of the Act, every licensee of a long-term care home shall ensure that the following devices are not used in the home:
1. Roller bars on wheelchairs and commodes or toilets.
2. Vest or jacket restraints.
3. Any device with locks that can only be released by a separate device, such as a key or magnet.
4. Four point extremity restraints.
5. Any device used to restrain a resident to a commode or toilet.
6. Any device that cannot be immediately released by staff.
7. Sheets, wraps, tensors or other types of strips or bandages used other than for a therapeutic purpose. O. Reg. 79/10, s. 112.

Findings/Faits saillants :

1. The licensee has failed to ensure that the following devices are not used in the home 7. Sheets, wraps, tensors, or any other types of strips or bandages used other than for a therapeutic purpose.

On a specified day in 2019, resident #001 presented with increased agitation and ambulating behaviours in and out of their room. RN #104 gave directions to PSW #107 to sit resident #001 in wheelchair by the nursing station to help decrease and monitor the resident's responsive behaviours.

At a specified time of day, PSW #105, #106 and #108 arrived on the unit for the start of their shift. They noted that the resident was seated in the hallway, in a tilted wheelchair. The resident was agitated trying to sit in a more upright position in the wheelchair. PSW #105 attended to the resident and noted that a towel had been wrapped around the lap belt. The lap belt buckle was not accessible to the resident or staff. PSW #105 requested PSW #106's assistance with the provision of the resident's care. Both PSW #105 and #106 reported the incident to the home's Administrator.

The home's administrator and food nutrition manager reviewed the home's security footage. The security footage showed that the resident had been brought by PSW #107, in a tilted wheelchair to the nursing station at a specified time. The resident was wearing little clothing at that time. At approximately 15 minutes later, the resident was noted to be agitated and trying to get up out of the wheelchair. PSW #107 then applied a towel to the lap belt. Two hours later, the resident was found by PSWs #105 and #106 seated by the nursing station, in the tilted wheelchair, agitated and with a towel wrapped around the wheelchair lap belt. The Administrator said that PSW #107 had admitted to wrapping the towel around the lap belt to prevent resident #001 from undoing the lap belt as well as tilting the wheelchair to prevent resident #001 from getting up and out of the wheelchair. PSW #017 said that they took these actions as the resident had been undoing the lap belt and trying to get out of the wheelchair.

As such, on a specified day in 2019, PSW #107 applied a towel in a non-therapeutic manner, wrapping it around a lap belt to and limit resident #001's movement in a tilted wheelchair for a period of approximately 2 hours. [s. 112.]

Additional Required Actions:

VPC - 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 to ensure that the following devices are not used in the home:
1. Roller bars on wheelchairs and commodes or toilets
2. Vests or jacket restraints
3. Any device with locks that can only be released by a separate device, such as a key or magnet
4. Four point extremity restraints
5. Any device used to restrain a resident to a commode or toilet
6. Any device that cannot be immediately released by staff
7. Sheets, wraps, tensors, or other types of strips or bandages used other than for a therapeutic purpose, to be implemented voluntarily.

Issued on this 23rd day of September, 2019

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

Original report signed by the inspector.