Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jan 10, 2020	2020_818502_0001	022330-19	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

JULIENNE NGONLOGA (502)

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 6 and 7, 2020, and (off-site) January 8, 2020.

The following intake was inspected:
- Log #022330-19 a complaint related to alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Nursing (DON), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Resident Support Worker (RSW) and the resident.

During the course of the inspection, the inspector reviewed the resident's health care records, observed staff and resident interactions, and reviewed licensee's investigation notes.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

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	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. 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 abuse of resident #001 by PSWs has occurred, immediately report the suspicion and the information upon which it was based to the Director.

The Ministry of Long-Term Care received an anonymous complaint on an identified date related to an incident of alleged staff to resident abuse.

Review of the complaint indicated resident #001 brought to staff's attention that two Personal Support Workers (PSWs) were rough during an identified care. The resident also showed staff specified signs of the interaction with the PSWs. Staff reported this allegation to the home's Administrator and an internal investigation was initiated.

Review of the resident's progress notes indicated that on the day resident #001 reported the alleged abuse to staff, the Director of Nursing (DON) documented that their visit with resident #001 as part of the home's investigation. The DON noted the specified signs of the interaction with the PSWs mentioned above. The DON reported the incident to the Administrator of the home on the same day.

Two months after reporting the alleged abuse mentioned above to staff, resident #001 reported the incident to the Inspector. The resident stated that one of the PSW involved in the incident apologized the next day, but the apology meant nothing to them as they were hurt.

In an interview, the Administrator indicated that staff brought the alleged abuse mentioned above to their attention. The Administrator sated that they had initiated an investigation on the same day. The Administrator confirmed that they did not report the above mentioned allegation of PSW to resident #001 abuse to the Director under the LTCH Act 2010, as it was not substantiated. [s. 24. (1)]

Issued on this 13th day of January, 2020

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

Original report signed by the inspector.