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 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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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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
Nov 19, 2018	2018_770178_0022	010724-17, 018100-17, 025728-17, 002707-18, 006177-18, 007100-18	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 Cobden
12 Wren Drive P.O. Box 430 COBDEN ON K0J 1K0

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

SUSAN LUI (178)

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): October 26, 29, 30, 31, November 2, 6, 7, 8, 9, 13, 14, 2018.

The following Critical Incident Logs were inspected:
010724-17/2827-000018-17, 025728-17/2827-000031-17, and 006177-18/2827-000003-18, each regarding resident falls with injury.
018100-17/2827-000024-17, regarding a resident missing for three hours or more, resulting in an injury.
002707-18/2827-000001-18 and 007100-18/2827-000005-18, both regarding allegations of staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Resident Assessment Instrument (RAI) Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Health Care Aides, a former staff member, residents.

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

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 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. This non compliance is in regards to Critical Incident Intake #002707-18/CIR #2827-

000001-18.

The licensee has failed to ensure that resident #005 was protected from physical abuse by anyone.

The Long-Term Care Homes Act defines physical abuse as:
(a) the use of physical force by anyone other than a resident that causes physical injury or pain,
(b) administering or withholding a drug for an inappropriate purpose, or
(c) the use of physical force by a resident that causes physical injury to another resident.

Critical Incident Report (CIR) #2827-000001-18, which was submitted by the long-term care home on an identified date, reported the following incident of alleged abuse of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident: On an identified date, PSW #112 was witnessed tying resident #005's arm to the tub lift with a large stretchy rubber band known as a theraband, to restrain the resident's arm. When questioned by PSW #111 whether tying the resident this way was allowed, PSW #112 told the resident they would remove the band as long as the resident stopped performing an identified action, and then released the band. PSW #111 reported the incident to the home's Administrator approximately an hour later, and PSW #112 was placed on administrative leave pending completion of an investigation. Resident #005 was assessed for injuries, and none were apparent. During assessment, resident #005 recalled the incident and indicated that their arm hurt at the time of the incident, but was fine at the time of assessment. The resident's substitute decision maker, physician and the police were all notified of the incident.

During an interview with Inspector #178 on November 6, 2018, PSW #111 indicated that they had witnessed PSW #112 use a large rubber band to tie resident #005's hand and secure it to the lift strap, because the resident had been performing an identified action while the staff prepared the resident for a tub bath. PSW #111 indicated that PSW #112 tied the resident's hand in such a way that it was lifted up, raising the resident's hand in the air, and that resident #005 had indicated that it hurt their arm. PSW #111 indicated that they asked PSW #112 if tying the resident was allowed, and PSW #112 answered that it probably was not, and untied the resident, telling the resident they would replace the band if the resident began performing the identified action again. PSW #111 indicated that they considered PSW #112's actions to be physically and mentally abusive to resident #005, and they reported the incident to the Administrator.

During an interview with Inspector #178 on November 7, 2018, the Administrator indicated that on an identified date, they received a report from PSW #111 that they had witnessed PSW #112 tie resident #005's arm to the tub lift, using a theraband. The Administrator indicated that PSW #112 was placed on administrative leave and the incident was investigated by the home. The Administrator indicated that the home's investigation determined that PSW #112 had engaged in physical abuse of a resident, and PSW #112 is no longer employed by the home.

During an interview with Inspector #178 on November 7, 2018, PSW #112, who no longer works for the licensee, indicated that they did not tie resident #005's hand using an elasticized band, but that they did wrap a cloth around the resident's wrist, then wrapped the cloth around the strap of the lift sling. [s. 19. (1)]

2. This non compliance is in regards to Critical Incident Intake #007100-18/2827-000005-18.

The licensee has failed to ensure that resident #006 was protected from verbal abuse by anyone.

The Long-Term Care Homes Act defines verbal abuse as any form of verbal communication of a belittling or degrading nature which may diminish the resident's sense of well-being, dignity or self-worth made by anyone other than a resident.

Critical Incident Report (CIR) #2827-000005-18, which was submitted by the long-term care home on an identified date, reported the following incident of alleged abuse of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident: On an identified date, PSW #116 was witnessed repeatedly hitting resident #006 on the foot with the resident's walker, in an attempt the get the resident to move. When the resident called PSW #116 mean and began crying, PSW #116 stated "I'd be nicer to you if you rang less". The incident was witnessed by Student #117, who thereafter reported the incident to the home's Administrator. PSW #116 was sent home from the facility and placed on administrative leave pending completion of an internal investigation. Resident #006 was assessed for injuries, and none were identified. When interviewed after the incident, Resident #006 had no memory of anything unusual taking place, and indicated they have a poor memory. The resident's substitute decision maker, physician and the police were all notified of the incident.

During an interview with Inspector #178 on November 9, 2018, the Administrator

indicated that on an identified date, they received a report from Student #117 that while assisting PSW #116 to care for resident #006, Student #117 witnessed PSW #116 repeatedly hit resident #006 in the foot with the walker to get the resident to move. When the resident called PSW #116 mean, PSW #116 said that they would be nicer to the resident if the resident rang less. The Administrator indicated that PSW #116 was immediately placed on administrative leave and the incident was investigated by the home. The Administrator indicated that the home's investigation determined that PSW #116 had hit the resident on the foot repeatedly with the walker, and made comments to the resident about ringing too much, which made the resident feel badly about asking for the help the resident needed. The Administrator indicated that PSW #117 is no longer employed by the home. [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 residents are protected from abuse by anyone, to be implemented voluntarily.

Issued on this 5th day of December, 2018

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

Original report signed by the inspector.