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

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

London Service Area Office
291 King Street, 4th Floor
LONDON, ON, N6B-1R8
Telephone: (519) 675-7680
Facsimile: (519) 675-7685

Bureau régional de services de London
291, rue King, 4iém étage
LONDON, ON, N6B-1R8
Téléphone: (519) 675-7680
Télécopieur: (519) 675-7685

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 11, 2014	2014_229213_0007	L-000061-14	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 FERGUS NURSING HOME
450 QUEEN STREET EAST, FERGUS, ON, N1M-2Y7

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

RHONDA KUKOLY (213)

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): January 28, 2014

During the course of the inspection, the inspector(s) spoke with the Administrator, the Resident Care Coordinator, a Registered Practical Nurse, a member of the Activation staff and a Police Officer.

During the course of the inspection, the inspector(s) made observations, reviewed health records, policies and other relevant documentation.

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

Findings of Non-Compliance were found during this inspection.

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 LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with as evidenced by:
a) The home's policy "Abuse & Neglect" indicates under "Mandatory Reporting #1 All cases of suspected or actual abuse must be reported immediately in written form to the Director of Nursing (DON)/Administrator. In the absence of management staff, concerns should be reported immediately to the Charge Nurse, who will notify management staff on call".
b) Record review revealed that Resident #4 was inappropriately touched by Resident #2 on 2 occasions. These incidents were not reported to the DON/Administrator.
c) Record review revealed that Resident #3 was inappropriately touched by resident Resident #2 on 3 occasions. These incidents were not reported to the DON/Administrator.
d) Record review revealed that Resident #5 was inappropriately touched by resident Resident #2 on 3 occasions. These incidents were not reported to the DON/Administrator.
e) Record review revealed that Resident #6 was inappropriately touched by Resident #2 on 1 occasion. This incident was not reported to the DON/Administrator.
f) Record review revealed that Resident #1 was inappropriately touched by Resident #2 on 1 occasion. This was not reported to the DON/Administrator.
g) Incidents of inappropriate touching of unidentified female residents were documented in Resident #2's health record on 7 other occasions. These incidents were not reported to the DON/Administrator.
h) The Administrator confirmed that it is an expectation that the DON/Administrator is notified of any alleged, suspected or witnessed abuse and that she was not aware that these incidents of abuse had occurred. [s. 20. (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 the written policy that promotes zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, is immediately investigated as evidenced by:
a) Record review revealed that Resident #4 was inappropriately touched by Resident #2 on 2 occasions. These incidents were not documented in Resident #4's health record and were not investigated.
b) Record review revealed that Resident #3 was inappropriately touched by resident Resident #2 on 3 occasions. These incidents were not documented in Resident #3's health record and were not investigated.
c) Record review revealed that Resident #5 was inappropriately touched by resident Resident #2 on 3 occasions. These incidents were not documented in Resident #5's health record and were not investigated.
d) Record review revealed that Resident #6 was inappropriately touched by Resident #2 on 1 occasion. This incident was not documented in Resident #6's health record and it was not investigated.
e) Record review revealed that Resident #1 was inappropriately touched by Resident #2 on 1 occasion. This incident was not documented in Resident #1's health record and it was not investigated.
e) Incidents of inappropriate touching of unidentified female residents were documented in Resident #2's health record on 7 other occasions. These incidents were not investigated.
f) The administrator confirmed that it is an expectation that all of the documented incidents of inappropriate touching are documented in the Resident who was

inappropriately touched health record, reported and investigated. [s. 23. (1) (a)]

2. The licensee failed to ensure that appropriate action is taken in response to every such incident as evidenced by:
a) Record review revealed that Resident #4 was inappropriately touched by Resident #2 on 2 occasions. The Administrator and Resident Care Coordinator confirmed that appropriate actions were not taken related to these incidents.
b) Record review revealed that Resident #3 was inappropriately touched by resident Resident #2 on 3 occasions. The Administrator and Resident Care Coordinator confirmed that appropriate actions were not taken related to these incidents.
c) Record review revealed that Resident #5 was inappropriately touched by resident Resident #2 on 3 occasions. The Administrator and Resident Care Coordinator confirmed that appropriate actions were not taken related to these incidents.
d) Record review revealed that Resident #6 was inappropriately touched by Resident #2 on 1 occasion. The Administrator and Resident Care Coordinator confirmed that appropriate actions were not taken related to this incident.
e) Record review revealed that Resident #1 was inappropriately touched by Resident #2 on 1 occasion. The Administrator and Resident Care Coordinator confirmed that appropriate actions were not taken related to this incident.
e) Incidents of inappropriate touching of unidentified female residents were documented in Resident #2's health record on 7 other occasions. The Administrator and Resident Care Coordinator confirmed that appropriate actions were not taken related to these incidents. [s. 23. (1) (b)]

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 every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of, is immediately investigated and appropriate action is taken, to be implemented voluntarily.

WN #3: 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 failed to ensure that abuse of a resident by anyone that resulted in risk of harm and the information upon which it was based is immediately reported to the Director as evidenced by:
a) Record review revealed that Resident #4 was inappropriately touched by Resident #2 on 2 occasions. These incidents were not reported to the Director.
b) Record review revealed that Resident #3 was inappropriately touched by resident Resident #2 on 3 occasions. These incidents were not reported to the Director.
c) Record review revealed that Resident #5 was inappropriately touched by resident Resident #2 on 3 occasions. These incidents were not reported to the Director.
d) Record review revealed that Resident #6 was inappropriately touched by Resident #2 on 1 occasion. This incident was not reported to the Director.
e) Record review revealed that Resident #1 was inappropriately touched by Resident #2 on 1 occasion. This incident was not reported to the Director.
e) Incidents of inappropriate touching of unidentified female residents were documented in Resident #2's health record on 7 other occasions. These incidents were not reported to the Director.
f) The Administrator confirmed that it is an expectation that any alleged, suspected or witnessed abuse and the information upon which is based is reported to the Director. [s. 24. (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 abuse of a resident by anyone that resulted in risk of harm and the information upon which it was based is immediately reported to the Director, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's Substitute Decision Maker (SDM) and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident as evidenced by:
a) Record review revealed that Resident #4 was inappropriately touched by Resident #2 on 2 occasions. This Resident's SDM was not notified of these incidents.
b) Record review revealed that Resident #3 was inappropriately touched by resident Resident #2 on 3 occasions. This Resident's SDM was not notified of these incidents.
c) Record review revealed that Resident #5 was inappropriately touched by resident Resident #2 on 3 occasions. This Resident's SDM was not notified of these incidents.
d) Record review revealed that Resident #6 was inappropriately touched by Resident #2 on 1 occasion. This Resident's SDM was not notified of this incident.
e) Record review revealed that Resident #1 was inappropriately touched by Resident #2 on 1 occasion. This Resident's SDM was not notified of this incident.
e) Incidents of inappropriate touching of unidentified female residents were documented in Resident #2's health record on 7 other occasions. It is unknown if these Resident's SDM's were notified of these incidents.
f) The Administrator confirmed that it is an expectation that Resident's SDM's are notified of any alleged, suspected or witnessed abuse. [s. 97. (1) (b)]

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 resident's Substitute Decision Maker (SDM) and any other person specified by the resident are notified within 12 hours upon becoming aware of any alleged, suspected or witnessed incident of abuse of the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence as evidenced by:

a) Record review revealed that Resident #4 was inappropriately touched by Resident #2 on 2 occasions. These incidents were not reported to the police.
b) Record review revealed that Resident #3 was inappropriately touched by resident Resident #2 on 3 occasions. These incidents were not reported to the police.
c) Record review revealed that Resident #5 was inappropriately touched by resident Resident #2 on 3 occasions. This incident was not reported to the police.
d) Record review revealed that Resident #6 was inappropriately touched by Resident #2 on 1 occasion. This incident was not reported to the police.
e) Record review revealed that Resident #1 was inappropriately touched by Resident #2 on 1 occasion. This was not reported to the police.
e) Incidents of inappropriate touching of unidentified female residents were documented in Resident #2's health record on 7 other occasions. These incidents were not reported to the police.
f) The Administrator confirmed that it is an expectation that the appropriate police force is immediately notified of any alleged, suspected or witnessed abuse of a resident that the licensee suspects may constitute a criminal offence. [s. 98.]

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 appropriate police force is immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

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Issued on this 11th day of February, 2014

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

Rhonda Kukoly