Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

**Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue**


**Health System Accountability and Performance Division**
**Performance Improvement and Compliance Branch**
**Division de la responsabilisation et de la performance du système de santé**
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| Date(s) of inspection/Date(s) de l'inspection | Inspection No/ No de l'inspection | Type of Inspection/Genre d'inspection |
|---|---|---|
| Dec 22, 2011; Jan 6, 9, 2012 | 2011_087128_0030 | Critical Incident |

**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 HARRISTON
24 LOUISE STREET, P.O. BOX 520, HARRISTON, ON, N0G-1Z0

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

RUTH HILDEBRAND (128)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Critical Incident inspection.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, 1 Registered Practical Nurse, 3 Personal Support Workers/Health Care Aides, 1 nursing student and 3 residents.**

**During the course of the inspection, the inspector(s) reviewed the Critical Incident, the internal investigation report, one resident's clinical record, policies and procedures related to Resident Abuse, training related to abuse and Residents' Rights, as well as posting of Residents' Rights, zero tolerance of abuse, mandatory reporting and whistle blowing protection.**

**The following Inspection Protocols were used during this inspection:**

**Prevention of Abuse, Neglect and Retaliation**

**Responsive Behaviours**

**Findings of Non-Compliance were found during this inspection.**

## NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

| Legend | Legendé |
|---|---|
| WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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 subsections:**

**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. A review of the amended Critical Incident submission revealed that the home acknowledged that residents were not protected from abuse by staff in the home related to disciplinary action given to a staff member post investigation of incidents of abuse.
Staff interviews with the Administrator and Director of Care, December 22, 2011, confirmed that residents were not protected from abuse by an identified staff member of the home. They both acknowledged that disciplinary action of the staff member was taken related to incidents of abuse to residents.
The same day, resident interviews were conducted in the home. One of the residents stated that they did not feel safe in the home if an identified staff member was working and another resident stated that they were uncomfortable if the same staff member was working.
[LTCHA, 2007, S.O. 2007, c.8, 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 of the home are protected from abuse by anyone, to be implemented voluntarily.***

**WN #2: 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 subsections:**

**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.**
**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.**
**3. Unlawful conduct that resulted in harm or a risk of harm to a resident.**
**4. Misuse or misappropriation of a resident's money.**
**5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).**

**Findings/Faits saillants :**

1. A review of the Critical Incident submission confirmed that an investigation of abuse was initiated on December 5, 2011 but it was not submitted to the MOHLTC until December 9, 2011.
During a staff interview with the Director of Care, December 22, 2011, she acknowledged that she did not report the alleged/suspected abuse immediately to the Director after initially becoming aware of it on December 2, 2011.
[LTCHA, 2007, S.O. 2007, c.8, s.24(1)2]

***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 person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.***

**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents**

**Specifically failed to comply with the following subsections:**

**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. A review of the amended Critical Incident submission confirmed that an investigation of abuse was initiated on December 5, 2011 but the residents' substitute decision makers(SDMs) and any other person specified by the residents were not notified until December 20, 2011.
A staff interview with the Director of Care revealed that she first learned about the suspected abuse on December 2, 2011, but the residents' SDMs and any other persons specified by the residents were not notified within 12 hours as they were not notified until December 20, 2011.
[O.Reg.79/10, s.97 (1)(a)&(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 residents' SDMs and any other person specified by the resident are notified with 12 hours of becoming aware of any alleged, suspected or witnessed incidents of abuse or neglect of a resident, to be implemented voluntarily.***

**Issued on this 9th day of January, 2012**

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

Ruth Hildbrand