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

Ottawa Service Area Office
347 Preston St 4th Floor
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston 4iém étage
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 30, 2015	2015_360111_0008	O-000996-14, O-001830-15, O-001867-15	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 LINDSAY NURSING HOME
240 MARY STREET WEST LINDSAY ON K9V 5K5

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

LYNDA BROWN (111)

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): March 27 & 30, 2015

3 critical incident inspections (log 000996, 001867 & 001830) were completed concurrently during this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Behavioural Supports Ontario (BSO) staff, and residents. An observation of residents, review of health records, BSO meeting minutes, and the home's policy on Prevention of Abuse and Neglect, and review of the homes investigations were completed.

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

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	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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care for Resident #1 & Resident #2 set out clear directions to staff and others who provide direct care to the residents related to responsive behaviours.

Related to log #000996 & 001830:

A critical incident report(CIR) was submitted to the Director on a specified date for a resident to resident sexual abuse incident that occurred. The CIR indicated the witnessed incident occurred between Resident #1 towards Resident #2.

A second CIR was submitted to the Director six months later for a resident to resident sexual abuse incident that occurred. The CIR indicated the witnessed indicated occurred between Resident #1 towards Resident #2.

Interview of S#100 indicated Resident #1 is independently mobile. S#100 was aware of 2 incidents between Resident #1 and Resident #2, and indicated that staff are to ensure Resident #1 is not around Resident #2. S#1 indicated Resident #2 is also independently mobile but is more confused.

Interview of BSO member indicated the team meets monthly (with restorative care & RAI-Coordinator)to discuss and identify resident's with responsive behaviours and possible strategies to use. The BSO member indicated Resident #1 had a referral to Ontario Shores for an assessment after the second incident towards Resident #2 and both resident's care plans were updated at that time.

Review of the plan of care for Resident #1 indicated the resident demonstrated inappropriate sexual(verbal or physical) behaviour towards "other residents". Interventions included "protect other residents if unable to protect themselves".

Therefore, the care plan had no clear direction which "other residents" Resident#1 specifically was sexually inappropriate with (despite staff knowledge) or how staff were to "protect other residents if unable to protect themselves".

Review of the current plan of care for Resident #2 had no clear direction regarding which resident was sexually inappropriately towards the resident, or how staff would protect Resident #2 from any further incidents. [s. 6.(1) (c)]

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 plan of care for Resident #1 & #2 provides clear direction to staff and others that provide direct care to those residents related to responsive behaviours, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the behavioural triggers were identified for the resident demonstrating responsive behaviours (where possible) and that strategies were developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

Related to log # 001867:

A Critical Incident Report (CIR) was submitted to the Director on a specified date for a resident found exhibiting a high risk responsive behaviour.

Review of the health care record for Resident #3 indicated the resident was admitted to the home nine months prior with a history of demonstrating the high risk responsive behaviour. The resident was also demonstrating difficulty adjusting to Long Term Care. The resident (and prior psycho-geriatric assessments) identified specific triggers and strategies to manage the high risk responsive behaviour and to reduce the safety risk to the resident.

Review of progress notes for Resident #3 (during a seven month period leading up to incident) indicated the resident had demonstrated ongoing responsive behaviours which were identified as increasing safety risk to the resident. The identified triggers were also demonstrated and the identified strategies to manage the responsive behaviours (and identified as effective in reducing the risk to the resident) were inconsistently utilized.

Review of the care plan for Resident #3 (in place prior to incident) did not indicate the resident's:
-prior history of high risk responsive behaviour (which increased the safety risk to the resident under responsive behaviours),
-the identified triggers that increased the risk for safety to the resident,
-or strategies to use to reduce the risk of injury to the resident and manage the responsive behaviour. The plan of care was not revised until 4 days after the resident demonstrated the high risk responsive behaviour (which led to a near miss incident) The associated triggers related to the high safety risk behaviour (as indicated in current progress notes and ongoing consultation reports from psycho-geriatric assessments) were also not identified until after the incident occurred. The strategies identified by the physician and psycho-geriatric assessments were not consistently implemented, and the need for monitoring/reporting to psycho-geriatric team (as requested by the spouse). The written plan of care was also not revised until the initiation of this inspection.

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 resident's demonstrating responsive behaviours, have the behaviours identified (where possible), have the triggers identified related to those responsive behaviours(where possible), and have strategies developed and implemented (where possible)to manage those behaviours, to be implemented voluntarily.

Issued on this 19th day of May, 2015

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

Original report signed by the inspector.