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

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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 13, 2017	2017_603194_0003	034336-16	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 LINDSAY NURSING HOME
240 MARY STREET WEST LINDSAY ON K9V 5K5

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

CHANTAL LAFRENIERE (194)

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): on site on January 3,4, 5,off site January 9, 10, 2017

The following complaint was inspected Log# 034336-16 related to allegations of resident to resident sexual abuse

During the course of the inspection, the inspector(s) spoke with Administrator, Acting Director of Nursing (DON), Resident Care Coordinator (RCC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW) and Residents

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

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	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. 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 has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated:
(i) Abuse of a resident by anyone

On an identified date, PSW #119 reported an allegation of sexual abuse between resident #001 and resident #005 to Administrator and RN #120.

Resident #001 was admitted to the home with cognitive impairments. Resident #001 is dependent on staff for ADL's but able to self propel independently with wheelchair. Resident #005 was admitted to the home with cognitive impairments, required only minimal assistance with ADL's and was able to ambulate in the home independently.

PSW #119 indicated to Inspector #194 during a telephone interview on January 9, 2017, reporting to RN #120 allegations of inappropriate behaviour between resident #001 and resident #005 on an identified date. During the same telephone interview PSW #119 indicated witnessing resident #001 being sexually inappropriate towards resident #005. PSW #119 indicated to inspector informing the Administrator that he was "required to intervene in the situation", then turned to RN #120 stating that "resident #001 was being inappropriate with resident #005". PSW #119 indicated that the Administrator entered the room and spoke to resident #001 and RN #120 removed resident #005 from the area.

RN #120 indicate to inspector #194 during telephone interview on January 11, 2017, that

on identified date PSW #119 reported that resident #001 was being inappropriate towards resident #005. RN #120 indicated being with the Administrator at the time and they both entered the area to find resident #001 sitting in a wheelchair facing resident #005 . RN #120 indicated that resident #001 was being sexually inappropriate towards resident #005. RN #120 indicated that the Administrator spoke to resident #001 and RN #120 removed resident #005 from the area.

The Administrator indicated to inspector #194 during interview that on identified date that he had been directed by PSW #119 to intervene between resident #001 and resident #005. The Administrator indicated to inspector at time of interview not witnessing any sexually inappropriate behaviour between the resident #001 and resident #005 when the residents were observed and no further investigation was conducted.

Review of the progress notes was completed by inspector #194 and indicated that on identified date resident #001 was witnessed being sexually inappropriate towards resident #005.

The allegation of sexual abuse reported by PSW #119 on identified date was not immediately investigated. [s. 23. (1) (a)]

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 ensuring that every alleged, suspected or witnessed incident of abuse of a resident by anyone is immediately investigated, to be implemented voluntarily.

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Issued on this 13th day of January, 2017

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

Original report signed by the inspector.