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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 18, 2017	2017_670571_0011	000963-17, 010111-17, 012356-17, 016661-17	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

PATRICIA MATA (571), SARAH GILLIS (623)

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): July 24, 25, 26, 27, 28, 31 and August 1, 2, 3, and 4, 2017.

The following critical incident logs were inspected:
010111-17 and 012356-17 related to alleged staff to resident neglect; 000963-17 related to alleged resident to resident sexual abuse; 016661-17 related to potential for resident to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing (DON), Resident Care Coordinator (RCC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW) and residents.

In addition to interviews, policies were reviewed, residents were observed, staff to resident interactions were observed, clinical health records were reviewed and administrative records were reviewed.

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. 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 their policy that promotes zero tolerance of abuse is

complied with.

To summarize, a review of the licensee's policy: Abuse & Neglect - Staff to resident, family to resident, resident to resident, resident and/or family to staff (last reviewed February 2017) indicated:
Definition of sexual abuse: (b) any non-consensual touching, behaviour or remark of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.
Reporting:
1. All cases of suspected or actual abuse must be reported immediately to the DON/Administrator. In the absence of management staff, concerns should be reported immediately to the Charge Nurse, who will notify management staff on call.

A review of the licensee's policy Whistle-Blowing Protection and Staff Reporting (last revised May, 2017) indicated:
Reporting certain matters to the Director: 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: 2. Abuse of a resident by anyone

Re: Critical Incident Log # 01661-17:

A review of resident #001's current plan of care indicated a focus for an identified responsive behaviour towards other residents and staff.

A review of the clinical health records indicated that on a specified date and time, RPN #124 was informed by PSW # 121 that resident #001 displayed an identified responsive behaviour toward resident #003. Resident #003 is incapable of giving consent. RPN #124 documented that she talked to resident #001 and informed the resident that the behaviour was inappropriate. RPN # 124 left a message for resident #001's Substitute Decision Maker to call back regarding the incident. RN #125 documented that she spoke to resident #001 regarding the incident. RCC #108 documented the next day that he had reviewed the incident and indicated what interventions were initiated to prevent the behaviour from reoccurring in the future.

In an interview on August 4, 2017, with Inspector #571, PSW #121 indicated she observed resident #001 display an identified responsive behaviour toward resident #003 and reported the incident to RPN #124. RPN #124 documented on the incident and was

not available for an interview. In a telephone interview on August 10, 2017 with Inspector #571, RN #125 indicated that she was informed of the incident but cannot remember who informed her. RN #125 did not report the incident to the Director as the incident occurred the previous shift so she assumed it had been reported to the Director and to the licensee by the RN working at the time of the incident. RCC #108 indicated that he was aware of the incident but did not know why it was not reported. RCC #108 was not responsible for completing Critical Incident reports at the time of the incident and was not on-call at the time of the incident. In a separate interview with the Administrator on July 24, 2017, he indicated that the incident was not reported. The DON for the home at the time of the incident was no longer employed by the licensee and therefore was not interviewed.

The licensee failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with.

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 by ensuring that their policy that promotes zero tolerance of abuse is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

1. The licensee has failed to ensure that direct care staff were advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, required heightened monitoring because those behaviours posed a potential risk to the resident or others.

Re: Critical Incident Log # 01661-17:

A review of the clinical health records indicated that resident #001 displayed an identified responsive behaviour towards resident #003 on a specified date and resident #002 on a later separate date.

On July 24, 2017, several direct care staff that were working on the wing where resident #001 resides were interviewed separately by Inspector #571. PSW #107, #106, #105 and #101 indicated in their interviews that they were not aware that resident #001exhibitied an identified responsive behaviour towards other residents.

In an interview with Resident Care Co-ordinator (RCC) #108 on July 24, 2017, he indicated that he is the lead for the licensee's Behavioural Support Ontario (BSO) team in the home. Resident #001 was not on the BSO caseload for responsive behaviours. RCC #108 was not aware of the incident of an identified responsive behaviour of resident #001 toward resident #002 that occurred on a specified date. RCC #108 indicated that for residents exhibiting responsive behaviours, the initials of the resident are put on a white board hung in the nursing room with the resident's behaviours, triggers and interventions so that staff are alerted of behaviours and informed. A behavioural assessment tool (BAT) may also be implemented and utilized. On July 24, 2017, resident #001's initials, identified responsive behaviours and interventions were not on the white board and and RCC # 108 indicated that they had never been put on the board. In addition, there was no evidence that a behavioural assessment tool was initiated.

The licensee failed to ensure that direct care staff were advised at the beginning of every shift that resident #001 had identified responsive behaviours toward other residents that required heightened monitoring because those behaviours posed a potential risk to the resident.

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 by ensuring that (b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others, to be implemented voluntarily.

Issued on this 19th day of September, 2017

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

Original report signed by the inspector.