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

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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_0012	000948-17, 001669-17, 006282-17, 009303-17, 010862-17, 014368-17, 015842-17, 016672-17	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

PATRICIA MATA (571), SARAH GILLIS (623)

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

The following complaint logs were inspected:
000948-17 and 016672-17 related to alleged staff to resident verbal abuse; 001669-17 related to alleged resident to resident sexual abuse; 006282-17 and 014368-17 related to 24/7 RN coverage in the home; 009303-17 related to the falls program; 010862-17 related to alleged resident abuse; 015842-17 related to responsive behaviours.

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
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times, except as provided for in the regulations.

Related to log #006282-17 and 014368-17:

Two separate complaints were received by the Director on two separate specified dates which indicated that there was no Registered Nurses (RN) in the building for a specified time period.

A review of the RN staffing schedules for a five month period indicated that there were two identified dates where there was no RN in the building for a specified time period.

During an interview on July 26, 2017 by Inspector #623, the Administrator indicated that on both of the specified dates there was no RN in the building but there was an RN manager on call. The Administrator indicated that there had been RN's scheduled for both shifts but the RN's were unable to work the shift for two separate specified reasons. There was no other RN available to cover the shift. The Administrator indicated that he was aware of the legislative requirements for 24/7 RN staffing and that all efforts were exhausted to cover the shifts and they were unable to cover the RN shift.

The licensee failed to ensure that there is at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times in the home.

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 there is at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times, except as provided for in the regulations, 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:

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 has failed to ensure that a person who had reasonable grounds to suspect that (2) abuse of a resident by anyone that resulted in harm or risk of harm occurred, immediately reported the suspicion and the information upon which it was based to the Director.

Re: Complaint log #010862-17:

A review of the clinical health records indicated that on a specified date and time, resident #015 was found inside resident #010's room. Staff heard yelling and responded. Resident #010 indicated that he/she had been injured by resident #015. Agency RN #126 indicated resident #010 had a visible injury and was upset. Agency RN #126 indicated that she reported the incident to the DON.

In an interview with Inspector #571 on August 4, 2017, the DON indicated that she did not report the incident of alleged physical abuse to the Director because resident #010 did not need to go to the hospital for treatment. Agency RN #126 was not available for an interview.

Therefore, the licensee failed to ensure that an allegation of physical abuse that injured and caused pain to resident #010, was immediately reported to the Director.

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 physical abuse of a resident by anyone, that results in harm, is immediately reported to the Director, to be implemented voluntarily.

WN #3: 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 strategies had been developed and implemented to respond to resident #002, who was demonstrating responsive behaviours.

RE: Complaint Log #015842-17:

A review of the clinical health record indicated that on two separate dates, resident #002 displayed responsive behaviour that upset resident #018.

After review of resident #002's current plan of care, no evidence of interventions to address resident #002's specified responsive behaviour towards resident #018 could be found.

The progress notes further indicated that resident #018 was displaying a specified behaviour to avoid resident #002's specified responsive behaviour. In an interview on August 3, 2017, with Inspector #571, PSW #118 indicated that resident #018 did display the specified behaviour to avoid resident #002's responsive behaviour and PSW #118 believed that resident #018 was afraid of resident #002. PSW #118 indicated she was not aware of any interventions put into place to prevent resident #002 specified responsive behaviour towards resident #018 until August 3, 2017, when the care plan was updated. The plan of care was updated on August 3, 2017, after Inspector #571 interviewed RCC #108.

Therefore, the licensee failed to ensure that strategies had been developed and implemented to respond to the resident #002's responsive behaviour of throwing liquids on resident #018.

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 strategies been developed and implemented to respond to resident #002's responsive behaviours, to be implemented voluntarily.

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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.