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 prévue 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 Rapport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jun 4, 2019 | 2019_593573_0012 | 026690-17, 028127-17, 008402-18, 009336-18, 010241-18, 019730-18, 020137-18, 022151-18, 023817-18, 026599-18, 028749-18, 030676-18, 033111-18, 004065-19, 004068-19, 004069-19 | 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

ANANDRAJ NATARAJAN (573), AMANDA NIXON (148), EMILY BROOKS (732), SUSAN LUI (178)

## 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): May 06, 07, 08, 09, and 10, 2019.**

**The following Critical Incident System (CIS) intakes were inspected during this inspection:**

**Log(s) #028127-17 and 022151-18 related to an allegation of staff to resident physical abuse and neglect.**
**Log(s) #026690-17, 008402-18 and 028749-18 related to an allegation of resident to resident sexual abuse.**
**Log(s) #019730-18, 026599-18 and 033111-18 related to fall incident that causes an injury to a resident for which the resident is taken to hospital and which results in a significant change in the resident's health status.**
**Log #023817-18 related to allegation of improper care of a resident. Area of non-compliance identified for log #023817-18 was issued under complaint inspection # 2019_730593_0015.**

**The following Follow up intakes were inspected concurrently during this inspection:**

**Log #004065-19 – Follow Up: CO#001 related to Duty to protect s. 19. (1) Compliance due date April 30, 2019.**
**Log #004068-19 – Follow Up: CO#002 related to Safe storage of drugs r. 129. (1) Compliance due date February 28, 2019.**
**Log #004069-19 – Follow Up: CO#003 related to Administration of drugs r. 131. (2) Compliance due date April 30, 2019.**

**During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Resident Care Coordinators (RCC), Physician, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Behavioural Support Staff, Nurse Educator, Ward Clerk and residents.**

**During the course of the inspection, the inspector(s) observed medication storage areas, observed medication administration, reviewed resident health records, reviewed licensee records of investigations into allegations of abuse and improper**

**care, reviewed relevant licensee's policies, protocol and procedures. Reviewed staff training materials and attendance records. In addition, Inspectors observed the provision of care and services to the residents, staff to resident interactions and resident to resident interactions.**

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

**During the course of this inspection, Non-Compliances were issued.**
- **5 WN(s)**
- **4 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

**The following previously issued Order(s) were found to be in compliance at the time of this inspection:**
**Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:**

| REQUIREMENT/ EXIGENCE | TYPE OF ACTION/ GENRE DE MESURE | INSPECTION # / NO DE L'INSPECTION | INSPECTOR ID #/ NO DE L'INSPECTEUR |
|---|---|---|---|
| O.Reg 79/10 s. 129. (1) | CO #005 | 2018_598570_0013 | 178 |
| O.Reg 79/10 s. 131. (2) | CO #006 | 2018_598570_0013 | 178 |
| LTCHA, 2007 S.O. 2007, c.8 s. 19. (1) | CO #001 | 2018_598570_0013 | 148 |

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>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. 6. Plan of care**

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

**s. 6. (9) The licensee shall ensure that the following are documented:**
**1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).**
**3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the provision and outcomes of the care set out in the plan of care for resident #022 was documented. The details regarding holding the administration of resident #022's specific medication, were not documented.

Resident #022's electronic Medication Administration Record (eMAR) for specified dates in 2019, was reviewed by Inspector #178. Resident #022 was prescribed with a specific medication. The eMAR indicated that the prescribed dosage of this medication was not administered on two specified date and time, and the eMAR directed the reader to "see nurse notes". No documentation was present in the resident's nurse notes or medical record, documenting why the specific medication was not administered as directed or to indicate that the prescriber was notified. The initials on the eMAR indicated that the nurse on both of these occasions was RPN #129.

RPN #129 indicated to Inspector #178 that on a specified date and time, resident #022's specific medication was not administered because the resident's test result of a specified test were at an below identified level. RPN #129 indicated that the doctor or nurse practitioner (NP) is always informed if a resident's specific medication is held, so further direction can be obtained if necessary. RPN #129 indicated that they called the NP on a specified date, to inform them that the medication was being held due to the resident's specified test result, and the NP told them that it was okay to hold the medication. RPN #129 indicated that they documented on the eMAR that the specific medication was not given, and to see the nurse notes, but then forgot to document the details in a nurse note.

RPN #129 indicated they could not remember the details of why resident #022's specific medication was held on an identified date and time, but indicated that the RN working that evening checked resident #022's specified test result and would have directed RPN #129 to hold the medication if the resident's specified test result were at an below identified level. The RN should have then informed the doctor, and obtained further direction as needed.

RN #105 indicated to Inspector #178 that on a specified date and time, they checked resident #022 and documented the resident's specified test result at an identified level. RN #105 indicated that for a specified test result at an identified level they would have instructed the RPN to hold resident #022's specific medication, and would have informed the doctor as soon as possible to obtain further directions as needed. RN #105 indicated they should have documented in a progress note that the specified medication was held and why, and that the doctor was informed. Any further directions from the doctor would

also be written in resident #022's Physicians Orders. RN #105 indicated that they always inform the doctor if the specific medication is not administered as prescribed, and if no progress note was present documenting that resident #022's medication was held on specified date and time, then they must have forgotten to write the note. [s. 6. (9)]

***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 provision and outcomes of the care set out in the plan of care was documented, to be implemented voluntarily.***

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**WN #2: 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. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,**
**(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).**
**(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).**
**(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).**
**(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).**
**(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).**
**(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).**
**(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).**
**(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents, at minimum, contain an explanation of the duty under section 24 to make mandatory reports

On January 22, 2019, the licensee was issued an Order of the Inspector Report (#2018_598570_0013) to which Compliance Order #001 was issued. Among other items, the CO directed the licensee to train all staff on the policy to promote zero tolerance of abuse and neglect of residents, specifically immediate reporting.

The policy to promote zero tolerance of abuse and neglect of residents was identified as the Abuse and Neglect – Staff to Resident, Resident to Resident, Resident and/or Family to Staff policy, reviewed September 2018.

The policy contains the following statement:  The Executive Director/DOC who has reasonable grounds to suspect that any of the following has occurred or may occur must immediately report that suspicion and the information upon which it is based to the Director. Items to be reported include improper or incompetent treatment, abuse and neglect, unlawful conduct, misuse or misappropriate of a resident's money or misuse or misappropriation of funding.

Inspector #148 interviewed three registered nursing staff and two PSWs regarding mandatory reporting. All staff indicated that their role was to report to the charge nurse and/or the Executive Director or DOC. When asked, the staff members indicated that they do not have a role in contacting the Director/MOHTLC.

The Inspector spoke with the Nurse Educator who provided training to all staff related to the policy to promote zero tolerance of abuse and neglect of residents. The Nurse Educator indicated that the training focused on the internal reporting process; mandatory reporting, as described by s.24 of the LTCHA, 2007, was not discussed.

In addition, a written notification (WN #3) has been issued under s.24 (1) related to the licensee's failure to report alleged resident abuse immediately to the Director. [s. 20. (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 the written policy to promote zero tolerance of abuse and neglect of residents, at minimum, contain an explanation of the duty under section 24 to make mandatory reports, to be implemented voluntarily.***

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**WN #3: 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 has reasonable grounds to suspect that 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, has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

On a specified date and time, RCC #103 submitted a critical incident report to the Director describing that on a specified date, PSW #127 observed resident #004 to resident #005 alleged sexual abuse incident. The PSW reported the incident to RPN #120 on the next day. The incident was then reported to RCC #103, a day after the incident, at which time a report to the Director was made.

On a specified date and time, RCC #103 submitted a critical incident report to the Director describing that a day before, RPN #120 observed resident #004 to resident #003 alleged sexual abuse incident. RPN #120 informed RPN/BSO #104 of the incident. RPN/BSO #104 indicated to the Inspector that it is likely a report was made to RCC #103 on the same day. RCC #103 does not recall receiving a report on the same day when the incident occurred. RCC #103 indicated to the Inspector that the RCC was made aware of the incident a day after, at which time a report to the Director was made.

As it relates to the alleged resident sexual abuse on two specified dates, the alleged sexual abuse was not reported immediately to the Director. [s. 24. (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 the person who has reasonable grounds to suspect that 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, 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.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 80. Every licensee of a long-term care home shall ensure that residents have access to medical services in the home 24 hours a day. O. Reg. 79/10, s. 80.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that residents have access to medical services in the home 24 hours a day.

On May 9, 2019, RN #110 indicated to Inspector #178 that on three specified days in 2019, there was no on call doctor listed on the On Call Schedule. RN #110 indicated that during this period the home's Medical Director was on holidays. RN #110 indicated that they recognized on a specified date that no Doctor was listed on the On Call Schedule during this three day period, and they put a note on the Point Click Care (PCC) communication page asking RN #105 to follow up the concern the next day. RN #110 indicated that RN #105 charted on PCC on a identified date, that the doctor in charge of developing the On Call Schedule was not in the office, and the doctor would get back to the home about the weekend coverage. RN #110 indicated that the home did not receive the information identifying the on call doctor scheduled for this three day period.

On May 9, 2019, the DOC indicated to Inspector #178 that on call physician coverage for weekends is arranged by a local physician's office. The office provides the home with a list of on call physician coverage for weekends, and staff is expected to notify the doctor on call if the residents require medical attention during the weekends. The DOC indicated that there was no physician listed for on call coverage for the three specified day in 2019. The DOC indicated that it is the responsibility of the home's physician to ensure that there is always a Doctor on call, but that the home management should also ensure that on call coverage is in place. [s. 80.]

***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 have access to medical services in the home 24 hours a day, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system**

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

**s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,**
**(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).**
**(b) is on at all times; O. Reg. 79/10, s. 17 (1).**
**(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).**
**(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).**
**(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).**
**(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).**
**(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a resident-staff communication and response system, could be easily accessed and used by resident #001 at all times.

On May 7, 2019, Inspector #148 observed resident #001 in the resident's room. The resident was seated in a comfortable chair with a bedside table situated between the bed and chair. The call bell panel (communication and response system) was located on the wall behind the head of bed with a red cord extending from the wall. The cord was then attached by use of a clip to the bedside table on the side nearest the bed. The resident identified the use of the call bell as a means to ask staff to attend the room. When asked by the Inspector to demonstrate, the resident was not able to reach the cord of the call bell.

On a subsequent observation on May 9, 2019, the resident was observed seated in a comfortable chair. The red cord extended from the call bell panel, laying on the floor wrapped under the wheel of the bedside table; the cord was attached to the end of the bedside table within reach of the resident. When asked to demonstrate the resident began to pull on the cord, however, the cord caught on the wheel of the table and the alarm could not engage.

Resident #001 was the recipient of alleged resident to resident sexual abuse, as indicated in the grounds for CO #001 (Inspector Report #2018_598570_0013). As described by RPN/BSO #104, the resident was encouraged to call for assistance from a staff member if another resident were to enter the room of resident #001. In addition, the resident's plan of care indicated the resident was at risk of falls and to call staff for assistance.

Resident #001 could not easily access and use the resident-staff communication and response system on May 7 and 9, 2019. [s. 17. (1) (a)]

Ontario

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**Rapport d’inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée***

**Issued on this 5th day of June, 2019**

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

**Original report signed by the inspector.**