Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

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
Nov 14, 2019	2019_785732_0034	014779-19, 014830-19, 015402-19, 016847-19, 016848-19, 017528-19, 019391-19, 020988-19	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

EMILY BROOKS (732), ANANDRAJ NATARAJAN (573), HEATH HEFFERNAN (622)

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): November 4 to 8, 2019

The following intakes were completed during this Critical Incident System (CIS) Inspection:

Log #015402-19 which is a follow-up to CO#001 from inspection #2019_664602_0032

Log #014779-19 (CIR 2701-000043-19) related to an unexpected death.

Log #016847-19 (CIR 2701-000054-19) and log #014830-19 (CIR 2701-000042-19) related to responsive behaviours and alleged physical abuse.

Log #016848-19 (CIR 2701-000056-19), log #017528-19 (CIR 2701-000059-19), log #020988-19 (CIR 2701-000066-19), and log #019391-19 (CIR 2701-000060-19) related to responsive behaviours and alleged sexual abuse.

Complaint inspection #2019_785732_0033 was completed concurrently with this CIS inspection. Non compliance was found in complaint inspection #2019_785732_0033 and will be issued in this CIS inspection.

The following logs were completed in complaint inspection #2019_785732_0033: Log #015968-19, log #015784-19 (CIR 2701-000048-19), log #015782-19 (CIR 2701-000049-19), and log #015716-19 (CIR 2701-000046-19) related to responsive behaviours and alleged abuse.

During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Resident Care Coordinator's (RCC), Registered Nurses (RN), the Behavioural Support Outreach Registered Practical Nurse (BSO RPN), Registered Practical Nurses (RPN), personal support workers (PSW), and residents.

In addition, the inspectors reviewed Critical Incident Reports (CIR), health care records, observation worksheets, and relevant policies and procedures. The inspector(s) also observed the provision of care and services to residents, resident care areas, and resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

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)**

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. 17. (1)	CO #001	2019_664602_0032	573

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	Légende 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 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 for each resident demonstrating responsive behaviours, 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.

A Critical Incident Report (CIR) indicated that there was a witnessed incident of resident #001 to resident #003 alleged physical abuse which caused a skin tear to one of resident #001's lower extremities, while resident #003 was not injured as a result.

Another CIR indicated that there was a witnessed incident of resident #001 to resident #008 alleged sexual abuse with no injury to either resident.

Resident #001 had a history of responsive behaviours.

During a telephone interview with inspector #622, Registered Nurse #105 stated that on a specified date, as the result of the incident of resident #001 to resident #003 alleged physical abuse, they immediately started the DOS data collection sheets and the licensee's 15 Minute Resident Check protocol.

A review of the DOS data collection sheet related to the incident of resident to resident alleged abuse on a specified date indicated it had not been implemented until the next day.

During two separate interviews with inspector #622, the Behavioural Support Registered

Practical Nurse (BSO RPN) #110 stated that the behavioural support protocol was that the Licensee's 15 Minute Resident Check protocol and the DOS data collection sheets were to be used for every major behavioural incident. BSO RPN #110 stated that they had implemented the DOS data collection sheet and the licensee's 15 Minute Resident Check protocol on a specified date, and on another specified date, as a result of the incidents of resident #001 to resident #003 alleged physical abuse and resident #001 to resident #008 alleged sexual abuse. Inspector #622 requested the DOS data collection sheets and the licensee's 15 Minute Resident Check protocol which had been implemented for the above two incidents. BSO RPN #110 was not able to produce the licensee's 15 Minute Resident Check protocol for one of the specified dates to support that it had been implemented or completed.

A review of the DOS data collection sheet dated for a specified time frame for resident #001, which was in place as a result of the incident of resident to resident alleged physical abuse, indicated that the DOS had not been completed on the following dates and times:

A specified date – 2400 hours to 0630 hours.
A specified date – 0700 hours to 1330 hours.
A specified date – 0700 hours to 1830 hours.

A review of the DOS, data collection sheet dated for a specified time frame for resident #001 which was in place as a result of the incident of resident to resident alleged sexual abuse, indicated that the DOS had not been completed on the following dates and times:

A specified date – 0030 hours – 0630 hours.
A specified date – 1130 hours – 1330 hours.
A specified date – 0700 – 1330 hours.
A specified date – 0700 – 1130 hours.

A review of the Licensee's 15 Minute Resident Check protocol for a specified time frame for resident #001 indicated that documentation had not been completed on a specified date from 0600 hours to 1300 hours.

During an interview with inspector #622, the Director of Care (DOC) #100 reviewed the licensee's behavioural support assessments which had been implemented due to resident #001's responsive behaviours. The assessments included the DOS data collection sheets implemented for the incident of resident #001 to resident #003 alleged

physical abuse, and the incident of resident #001 to resident #008 alleged sexual abuse. DOC #100 also reviewed the licensee's 15 Minute Resident Check protocol dated for a specified time frame. The DOC noted that the behavioural support documentation had not been completed on either of the DOS data collection sheets and the licensee's 15 Minute Resident Check protocol. DOC #100 stated that the behavioural support assessments related to resident #001's responsive behaviours should have been completed. [s. 53. (4) (c)]

2. A complaint was submitted to the Director alleging physical and sexual responsive behaviours from resident #009 to co-residents. Three Critical Incident Reports (CIR) were also submitted to the Director regarding the behaviours of resident #009. They included a CIR alleging physical abuse from resident #009 to resident #010, and two CIR's from the same date alleging sexual abuse from resident #009 to resident #011 and sexual abuse from resident #009 to resident #012.

Inspector #732 reviewed resident #009's electronic health care record. It was noted that resident #009 had a history of responsive behaviours. A progress note from a specified date, written by RN #113, described that resident #009 was found by a PSW in resident #010's bedroom. Resident #009 was standing behind resident #010 with an item in their hand holding it up to resident #010's neck and trying to strangle resident #010.

Inspector reviewed resident #009's progress notes for a specified date. A progress note written by RN #113 described resident #009 grab the buttocks and hand of resident #011 from behind, in the hallway. Resident #011 yelled "leave me", and resident #009 walked away. 15 minutes later, a subsequent incident of alleged sexual abuse occurred by resident #009. RN #113 documented that resident #009 was found by unit clerk #115 with both hands over the chest area of resident #012.

In an interview, Behavioural Support Outreach Registered Practical Nurse (BSO RPN) #110 explained to Inspector #622 that when a behavioural incident occurs, a 15 minute resident check and Dementia Observation System (DOS) worksheet are put out for staff to complete. BSO RPN #110 explained that any registered staff can initiate a 15 minute resident check and DOS worksheet, and that this should be initiated as soon as the behaviour is recognized. BSO RPN #110 explained to Inspector #732 that any staff member is responsible for filling out the above worksheets.

Inspector #732 reviewed resident #009's health care record and was unable to locate a DOS worksheet initiated for resident #009 for the alleged physical abuse incident, or for

the alleged sexual abuse incidents. Inspector #732 asked BSO RPN #110 if a DOS worksheet was started for resident #009 after the alleged physical abuse incident and they informed Inspector #732 that they had initiated a DOS observation worksheet after the incident. BSO RPN #110 and Director of Care (DOC) #100 were unable to provide Inspector #732 with the completed DOS worksheet for resident #009 after this incident. Resident #009's response to the intervention was not documented.

Inspector asked BSO RPN #110 if a DOS worksheet was initiated for resident #009 after the alleged sexual abuse incidents. BSO RPN #110 gave Inspector #732 a DOS worksheet dated two days after the alleged sexual abuse incidents and indicated that this was the DOS worksheet initiated for the two alleged sexual abuse incidents. Resident #009's DOS worksheet was not initiated when the behaviour was recognized.[s. 53. (4) (c)]

3. Two separate CIR's were submitted to the Ministry of Long-Term Care (MLTC) related to resident #004 to resident #005 alleged sexual abuse incident. Furthermore, another CIR was submitted to MLTC related to resident #004 to resident #006 alleged sexual abuse incident.

During an interview with the Behavioural Support Registered Practical Nurse (BSO RPN) #110, they indicated that following each incident a 15 minute resident check and DOS behaviour mapping was initiated for resident #004.

Inspector #573 reviewed resident #004's health care records in the presence of BSO RPN #110. Upon review, Inspector found that there was no DOS behaviour mapping tool for one of the incidents. Further, the DOS behaviour mapping tool initiated for another incident did not capture resident #004's behaviours on a specified date from 0100 hours to 1330 hours and on a specified date from 1400 hours to 2130 hours. The DOS behaviour mapping tool initiated for one of the incidents on a specified date, did not capture resident #004's behaviours on a specified date from 1400 hours to 2130 hours and on a specified date from 0930 hours to 1300 hours. A review of resident #004's 15 minute resident check documentation did not have any documentation for 3 specified dates. (Log (s) #016848-19/017528-19/019391-19)

Therefore, the licensee failed to ensure that resident #001, resident #009, and resident #004 who were demonstrating responsive behaviours, had actions taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented. [s. 53. (4) (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 for each resident demonstrating responsive behaviours, 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,, to be implemented voluntarily.

Issued on this 14th day of November, 2019

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

Original report signed by the inspector.