Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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
Jan 13, 2020	2020_694166_0003	020635-19, 024188-19, 024513-19, 000050-20	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

CAROLINE TOMPKINS (166), CHANTAL LAFRENIERE (194)

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): Janaury 9, 10, 2020

The intakes related to allegations of resident to resident abuse, an allegation of staff to resident abuse and a resident fall were inspected.

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

The following Inspection Protocols were used during this inspection:
Falls Prevention
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	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 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 has failed to ensure that the licensee's "Abuse and Neglect - Staff to Resident, Family to Resident, Resident to Resident, Resident and/or family to Staff" was complied with.

A Critical Incident Report (CIR) was submitted to the Director, reporting an allegation of staff to resident abuse. The CIR indicated a Personal Support Worker (PSW) #111 reported to Registered Nurse (RN) #110, an injury observed to resident #006. RN #110 assessed resident #006 and notified resident #006's Power of Attorney (POA) of the injury. RN #110 documented that the POA alleged the injury was a result of physical abuse by staff when providing care.

Review of the licensee's policy related to the reporting of resident abuse indicated: All cases of suspected or actual abuse must be reported immediately to the Director of Care/Executive Director. In the absence of management staff, concerns should be reported immediately to the charge nurse, who will notify management staff on call.

During interview with Inspector #194, RN #110 indicated that the on call manager was not notified of the allegations of abuse expressed by resident #006's Power of Attorney.

The licensee's policy for abuse was not complied with, when RN #110 did not report allegations of abuse involving resident #006, to the on call manager as directed by the licensee's resident abuse and neglect policy. [s. 20. (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 licensee written policy to promote zero tolerance of abuse and neglect specifically related to the reporting of alleged /witnessed abuse of residents is complied with, to be implemented voluntarily.

Issued on this 13th day of January, 2020

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

Original report signed by the inspector.