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

Central East Service Area Office
33 King Street West, 4th Floor
OSHAWA ON L1H 1A1
Telephone: (905) 440-4190
Facsimile: (905) 440-4111

Bureau régional de services de Centre-Est
33, rue King Ouest, étage 4
OSHAWA ON L1H 1A1
Téléphone: (905) 440-4190
Télécopieur: (905) 440-4111

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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 26, 2020	2020_640601_0009	000454-20, 002015-20, 002836-20, 002850-20, 010320-20	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

KARYN WOOD (601)

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 28, 29, June 2, 3, 4, 2020 (onsite) and June 5, 8 and 9, 2020 (off-site).

The following intakes were completed in this Critical Incident Report (CIR) Inspection:

Two logs related to a fall that resulted in a significant change in condition.

Two logs related to allegations of resident to resident abuse.

One log related to allegations of staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Resident Care Co-Ordinator (RCC) Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Behavioural Support Ontario/Registered Practical Nurse (BSO/RPN), Dietary Manager, Environmental Service Manager (ESM), Housekeeping staff, Hospital Infection Prevention Specialist and residents.

The inspector also reviewed resident health care records, observed the delivery of resident care and services, including staff to resident interactions and resident to resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for resident #002 that set out clear directions to staff and others who provided direct care to the resident related to the provision of continence care during an identified shift, on a specified date.

Review of a Critical Incident Report (CIR) that was submitted to the Director on a specified date and time for an alleged staff to resident neglect of resident #002, by PSW #108. The CIR incident involving PSW #108 and resident #002 indicated the resident had not received continence care on an identified shift and specified date. According to the CIR, PSW #105 and RPN #104 discovered resident #002 saturated with urine and stool, on a specified date and time.

Review of resident #002's written care plan by Inspector #601 identified that for a specified period of time, RPN #115 had written in the resident's plan of care for staff to allow the resident to wake up on their own for continence care and not to wake the resident during an identified shift, as the resident had specified responsive behaviours during continence care.

Review of resident #002's written care plan by Inspector #601 identified that on a different specified date, prior to the incident, the Director of Care (DOC) revised the resident's care plan with specified interventions to manage the resident's responsive behaviours.

Review of resident #002's written care plan by Inspector #601 identified that on a

specified date after the incident, resident #002's written care plan interventions included specific suggestions to help reduce the resident's responsive behaviours during continence care on the identified shift.

During separate interviews, RN #102, PSW #105, BSO/RPN #114 and RCC #110 indicated to Inspector #601 that resident #002 had specified responsive behaviours during continence care, on the identified shift.

During an interview, BSO/RPN #114 indicated to Inspector #601 that on a specified date, resident #002's continence care plan was revised to allow the resident to sleep during the identified shift and to provide continence care if the resident was awake. The resident required safety checks and the resident would receive continence care if they were awake on the specified shift. BSO/RPN #114 further indicated that resident #002 was frequently incontinent during the identified shift and continence care was required to keep the resident dry and comfortable. BSO/RPN #114 indicated a care plan review was completed prior to the incident, on a specified date and specific interventions were put into place to wake the resident slowly during the identified shift to reduce the specified responsive behaviours with continence care.

During an interview, RCC #110 indicated to Inspector #601 that resident #002's written care plan had been updated on a specified date to provide continence care during the identified shift prior to resident #002 being found saturated with urine and stool on the specified date. RCC #110 further indicated a Kardex review was not completed with staff and that PSW #108 indicated to RCC #110 that they were not aware of the revisions to resident #002's written care plan to provide continence care during the identified shift.

The licensee failed to ensure the written plan of care for resident #002 set out clear directions to staff and others who provide care when PSW #108 was not aware that resident #002's written care plan had been revised on a specified date. Resident #002's written care plan on a specified date was to not wake the resident for continence care during an identified shift. RCC #110 and BSO/RPN #114 indicated to Inspector #601 that resident #002's plan of care was revised on a specified date prior to the incident and staff were to wake the resident for continence care during the identified shift. Review of the resident's written care plan by Inspector #601 identified the care plan had been revised with specific instructions on a specified date, following resident #002 not being provided continence care during the identified shift, on the specified date. [s. 6. (1) (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 there is a written plan of care for residents that set out clear directions to staff and others who provided direct care to the residents, to be implemented voluntarily.

Issued on this 10th day of July, 2020

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

Original report signed by the inspector.