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
Mar 14, 2019	2019_800532_0002	008315-18, 008543-18, 009427-18, 009754-18, 015944-18, 016822-18, 016879-18, 017602-18, 020672-18, 022073-18, 022487-18, 023256-18, 026563-18, 028884-18, 029265-18, 029582-18, 030292-18, 032869-18, 003097-19, 004135-19	Follow up

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 Listowel Nursing Home
710 Reserve Avenue South LISTOWEL ON N4W 2L1

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

NUZHAT UDDIN (532), AMANDA OWEN (738), RHONDA RIDGEWAY (737)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): February 27, 28, March 1, 4, 5, 6, 7, 8, and 11, 2019.

The following Critical Incidents (CIs) were completed in conjunction with this inspection:
Log #009427-18, CI #2664-000011-18, Log #008543-18, CI #2664-000009-18, Log #022073-18, CI #2664-000023-18, Log #016822-18, CI #2664-000016-18, Log #004135-19, CI #2664-000005-19, Log #009754-18, CI #2664-000012-18, Log #028884-18, CI #2664-000034-18, Log #020672-18, CI #2664-000021-18, Log# 022487-18, CI #2664-000022-18, Log #032869-18, CI #2664-000040-18, Log #023256-18, CI #2664-000026-18, Log #008315-18, CI #2664-000008-18, Log #016879-18, CI #2664-000018-18, Log #026563-18, CI 2664-000031-18, Log #015944-18, CI #2664-000017-18, Log #029265-18, CI #2664-000036-18, Log #003097-19, CI #2664-000003-19, Log #030292-18, CI #2664-000038-18, Log #029582-18, CI #2664-000037-18, related to to alleged abuse and responsive behaviours.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator, Ward Clerk, Behaviour Support Ontario Staff (BSO), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Aide, residents and family members.

The inspectors also toured resident home areas and common areas, observed resident care provision, resident staff interaction, dining services, reviewed relevant residents' clinical records, relevant policies and procedures pertaining to the inspection.

The following Inspection Protocols were used during this inspection:
Falls Prevention
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)**

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. 53. (4)	CO #001	2018_580568_0007	532

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. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone.

For the purposes of the definition of "abuse" in subsection 2(1) of the Act,

Physical abuse is defined as the use of physical force by a resident that causes physical injury to another resident.

a) This inspection was completed in response to Critical Incident (CI) submitted to the Ministry of Health and Long Term Care (MOHLTC) in relation to resident to resident physical aggression.

Progress notes stated that an RN went to check on a resident and found the Behaviour Support Ontario (BSO) staff trying to separate two residents that were engaged in an altercation. During the altercation one of the resident's sustained an injury.

Clinical records for the identified resident noted an injury and the Electronic Treatment Record (eTAR) for altered skin integrity was initiated.

During an interview with the resident they recalled the events of the incident and showed where they had sustained the injury.

The RN stated that the resident sustained an injury by a co-resident and both residents were upset at the time of the incident.

b) A CI stated that a registered staff member observed a resident to resident altercation. The staff member observed an that one of the resident's sustained an injury. The identified resident involved in the altercation acknowledged that they had hit the co-resident.

Review of the clinical record and an interview with an RPN showed that the resident sustained an injury related to this incident. (738)

c) A CI indicated that an identified resident was agitated by another resident's responsive behaviour. According to staff that witnessed the altercation the resident hit the co-resident which resulted in an injury.

Clinical records indicated that the resident sustained an injury.

The DOC stated that the resident had responsive behaviours and was known to agitate other residents. The DOC acknowledged that the identified resident hit the resident causing an injury.

The licensee has failed to ensure that the residents were protected from abuse by anyone.

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 residents are protected from abuse by anyone, to be implemented voluntarily.

Issued on this 14th day of March, 2019

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

Original report signed by the inspector.