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 sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, L1K-0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, L1K-0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Sep 10, 2014	2014_365194_0013	O-00802-14,O-000863-14	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 ON MCLAUGHLIN ROAD
114 McLaughlin Road, LINDSAY, ON, K9V-6L1

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

CHANTAL LAFRENIERE (194), PATRICIA BELL (571)

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): September 2,3,4,&5, 2014

During the course of this inspection the following Critical Incident Logs were completed. Log #O-000802-14,#000863-14,#000374-14,#000443-14 and #000118-14.

PLEASE NOTE: One non-compliance was found related to the Licensee's failure to provide care as specified in plan of care under the Long-Term Care Homes Act.
This non-compliance LTCHA s.6(7) was issued in Inspection #2014_365194_0015, conducted on September 02, 2014 and is contained in the Report of that inspection

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care(DOC), Resident Care Coordinator(RCC), Registered Nurse (RN), Registered Practical Nurse (RPN), Personal Support Worker (PSW),Physio Therapist(PT),Behavioural Support Nurse (BSO),RAI Coordinator and Residents

During the course of the inspection, the inspector(s) reviewed clinical health records of identified residents, Internal abuse investigation notes, Internal Incident Reports, Licensee's policy on Abuse, Critical Incident Reporting, Responsive Behaviour, Medication records and Medication Incident Reports. Observed staff/resident provision of care.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

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	Legendé 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. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a missing or unaccounted for controlled substance was reported to the Director, no later than one business day after the occurrence of the incident.

Log # O-000374-14

The licensee initiated an internal investigation on April 06, 2014 for missing controlled substance.

The Administrator stated the police were informed of missing controlled substanceson April 15, 2014.

A Critical Incident Report to report missing controlled substances was submitted to the Director on April 24, 2014. [s. 107. (3)]

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 by ensuring that the Director is informed of any missing or unaccounted for controlled substances in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4), to be implemented voluntarily.

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. (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. This area of non compliance was issued July 31, 2014 to the home during inspection # 2014-360111_0018 under CO #003 with a compliance date of October 01, 2014

The licensee has failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Log #O-000802-14

Critical Incident related to abuse was reported to the Director. Resident #5 was observed by Staff #105 kissing Resident #4 on the mouth on an identified date.

A review of the policy Abuse and Neglect - Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff was reviewed. The policy entitled Resident to Resident Abuse directs; that the Caressant Care Internal Incident Report Form is to be completed by the Director of Nursing after any alleged/actual act of abuse.

Review of the clinical health records for Resident #5 and Resident #4 were completed as well as an interview with the Director of Nursing. No evidence of an incident report for this incident being completed was found. [s. 20. (1)]

Issued on this 10th day of September, 2014

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