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
Jun 4, 2019	2019_785732_0014	020966-18, 024631-18, 025363-18, 025708-18	Complaint

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

EMILY BROOKS (732), HEATH HEFFERNAN (622)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): May 27 - 31, 2019

The following intakes were completed during this complaint inspection:

Log #025708-18 related to medication administration
Log #025363-18, Log #024631-18, and Log #020966-18 related to personal support services, prevention of abuse, neglect and retaliation, and accommodation services

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), the Environmental Supervisor, residents, and family members.

In addition, the inspectors reviewed Critical Incident Reports (CIR), health care records, staff schedules, medication incident reports as applicable, maintenance records as applicable, and the licensee's abuse and neglect policy and procedure. The inspectors observed resident care areas, including bedrooms, and staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Critical Incident Response
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **3 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. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001's bed rail was maintained in a safe condition and in a good state of repair.

Inspector #622 reviewed the risk management notes from Point Click Care, documented by RN #114 on a specified date, which stated that at a specified time, resident #001 came out of their room on a specified device and were noted to be bleeding from a laceration to their lower extremity. Resident #001 had bumped into the bed rail on their bed with their specified device, the end of the bed rail was noted to be open and sharp.

During an interview with Inspector #622 on May 27, 2019, resident #001 stated that they could recall hitting the bed rail and cutting their lower extremity. They stated that there was a blanket covering the bed rail at the time and they did not see it. Inspector #622 observed the bed rail that resident #001 indicated they had hit on the exposed side of their bed. The bed rail was engaged and on the bottom side of the bed rail were two open tube ends, the metal was sharp.

During an interview with Inspector #622 on May 29, 2019, RN #114 stated that they worked the date when resident #001 cut their lower extremity on the bed rail in their room. The bed rail was the only sharp thing they could see that was at the level of resident #001's lower extremity and laceration. There were no plastic plugs noted on the sharp ends of the bed rail.

During an interview with Inspector #622 on May 28, 2019, Environmental Supervisor #103 and Inspector #622 observed resident #001's bed rail without plugs in the ends of the exposed sharp tubes. The Environmental Supervisor #103 stated that this was the bed and bed rails that resident #001 would have been using when they had the accident. The Environmental Supervisor #103 stated that the bed rail would normally have plastic plugs to keep residents from injury. The Environmental Supervisor #103 further stated that they had not replaced the plugs at the time of the incident as they were on vacation.

During an interview with Inspector #622 on May 29, 2019, Executive Director (ED) #101 indicated that the bed rail on resident #001's bed was not assessed after the incident and that Environmental Supervisor #103 had replaced the missing caps on the bed rail after Inspector #622 had brought it to their attention during this inspection. [s. 15. (2) (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 bed rails are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #2: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care is provided to resident #001 as specified in the plan.

A review of a complaint to the Ministry of Health and Long-Term Care (MOHLTC) indicated concerns with sleep routines for resident #001.

Inspector #622 reviewed the progress notes which indicated on a specified date at a specified time, resident #001's substitute decision maker had called the nursing home to inquire why resident #001 was not in bed.

Inspector #622 reviewed the care plan for a specified date, which stated that for bedtime routine, resident #001 preferred to go to bed around a specified time.

During an interview with Inspector #622 on May 29, 2019, agency Registered Nurse #112 stated that they worked the night of the call. Resident #001 had an established time they were to be in bed, and the resident was put to bed past the established time. [s. 6. (7)]

WN #3: 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. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents, at minimum, contains an explanation of the duty under section 24 to make mandatory reports.

The policy to promote zero tolerance of abuse and neglect of residents was identified as the Abuse and Neglect – Staff to Resident, Resident to Resident, Resident and/or Family to Staff policy, reviewed September 2018.

The policy contains the following statement: The Executive Director/DOC who has reasonable grounds to suspect that any of the following has occurred or may occur must immediately report that suspicion and the information upon which the suspicion is based to the Director appointed by the Ministry of Health and Long-Term Care. Items to be reported include improper or incompetent treatment, abuse and neglect, unlawful conduct, misuse or misappropriation of a resident's money or misuse or misappropriation of funding.

During an interview with Inspector #622, the Executive Director (ED) #101 reviewed the licensee's policy to promote zero tolerance of abuse and neglect of residents. ED #101 stated that the policy did not contain an explanation of the duty under section 24 for a person to make a mandatory report to the Director of the Ministry of Health and Long-Term Care. [s. 20. (2)]

Issued on this 6th day of June, 2019

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

Original report signed by the inspector.