Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Jan 18, 23, 24, 25, 2012	2012_043157_0004	Critical Incident

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

PATRICIA POWERS (157)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Substitute Decision-Maker (SDM) of an identified resident, one Registered Nurse (RN), two Personal Support Workers (PSW).

During the course of the inspection, the inspector(s) reviewed the clinical health records for three identified residents, reviewed Critical Incident Reports related to these residents, reviewed incident investigation documentation for incidents involving these three residents, reviewed personnel records related to the investigation of an incident involving an identified resident, reviewed the homes policies and procedures related to abuse and neglect, reviewed the home's hiring practices and educational programs related to resident abuse and neglect.

The inspector conducted two critical incident inspections related to two critical incidents: #2916-000033-11 (Log #002169-11) and #2916-000026-11(Log #001831-11).

The following Inspection Protocols were used during this inspection:

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following subsections:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;
(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. Results of the following investigations into allegations of abuse were not reported to the Director: [s.23(2)]
- Report of the results of an investigation into a reported incident of a PSW abuse of an identified resident witnessed by a family member and reported to the licensee in September, 2011. (Log #002169-11)
- Report of the results of an investigation into a reported incident of an identified resident who was witnessed by an RPN to be inappropriately touching another resident. (Log #001831-11)
2. In August, 2011, an incident was reported of an identified resident witnessed by an RPN to be inappropriately touching another resident. An investigation of this incident did not commence immediately (Log #001831-11)[s.23(1)(a)]

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 every alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee knows of or is reported to the licensee, is immediately investigated, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following subsections:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. In August an identified resident was witnessed by an RPN to be inappropriately touching another resident. The resident's SDM was not immediately notified of this incident. (Log #001831-11)[r.97(1)(a)]
2. There is no evidence to indicate that that the family of the resident was notified of the results of the investigation into these allegations.(Log #001831-11)[r.97(2)]

In September, 2011 a family member of an identified resident reported witnessing a staff member abuse the resident. The family member was not notified of the results of the investigation into this report.(Log #002169-11)[r.97(2)]

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 resident's substitute decision-maker is immediately notified of an alleged, suspected or witnessed incident of abuse or neglect of the resident and to ensure that the resident and the resident's substitute decision-maker are immediately notified of the results of an investigation, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. In September 2011, the family member of an identified resident reported to witnessing a staff member abuse the resident. The home did not immediately notify police of these allegations. (Log #002169-11)
2. In August, 2011, an identified resident was witnessed by an RPN to be inappropriately touching another resident. The police were not immediately notified of this incident. (Log #001831-11)

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 police are immediately notified of any alleged, suspected or witnessed incident of abuse or neglect that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #4: 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 subsections:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. In August, 2011 an identified resident was witnessed by an RPN to be inappropriately touching another resident. As a result of this incident, a professional consultant assessed the resident and recommendations for changes to the resident's plan of care were made.

There is no evidence these recommendations have been assessed or considered to be integrated into the resident's plan of care.
There is no evidence that staff and others involved in the resident's care collaborated with each other in the assessment of the resident or in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. (Log #001831-11)

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 staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident and in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, ss. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee failed to report the following incidents to the Director immediately [s.24(1)2.]:
- A family member of an identified resident reported witnessing two incidents of an identified PSW being abusive with the resident. The allegations were not immediately reported to the Director.(Log #002169-11)
- In August, 2011, an identified resident was witnessed by an RPN to be inappropriately touching another resident. The allegations were not immediately reported to the Director. (Log #001831-11)

WN #6: 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 subsections:

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;
(b) shall clearly set out what constitutes abuse and neglect;
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect;
(d) shall contain an explanation of the duty under section 24 to make mandatory reports;
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents;
(f) shall set out the consequences for those who abuse or neglect residents;
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and
(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 facility Policy "Abuse & Neglect - Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff" - Effective March, 2011:
- does not provide interventions to deal with persons who have abused or neglected or allegedly abused or neglected residents as required by O.Reg 79/10,s.96.(b).
- does not direct the immediate notification to the resident's substitute decision maker of an alleged, suspected or witnessed incident of abuse or neglect of the resident as required by O.Reg 79/10,s.97.(1)(a).
- does not provide clear direction for the immediate notification of police if the licensee suspects that any alleged, suspected or witnessed incident of abuse or neglect of a resident may constitute a criminal offence as required by O.Reg 79/10,s.98.
- does not provide direction to immediately report to the Director, any allegation of abuse or neglect of a resident that resulted in harm or risk of harm to the Director as required by LTCHA, 2007, c.8, s.24(1)2.

Issued on this 27th day of January, 2012

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