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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 31, 2014	2014_360111_0018	O-000081-14	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 ON MCLAUGHLIN ROAD
114 McLaughlin Road, LINDSAY, ON, K9V-6L1

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

LYNDA BROWN (111), PATRICIA BELL (571)

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): June 11, 14-18 & 21, 2014

Three complaint inspections (log# 000217, 000107 & 000108) & one critical incident inspection (log # 000243) was completed concurrently during this inspection. Additional non-compliance was identified for log#000217 but was indicated under inspection #2014_32571_0011.

During the course of the inspection, the inspector(s) spoke with The Administrator, the Resident Care Coordinator(RCC), Behavioural Support Ontario (BSO) Leads, RAI Coordinator (RAI),Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Program Manager (PM),Activity Aides, Dietary Manager, Food Services Manager (FSM), and Residents.

During the course of the inspection, the inspector(s) Observation of residents, review of health care records of current and deceased residents, review of polices (prevention of abuse and neglect, pain, safety plan, code care, missing & wandering residents, and responsive behaviours).

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Pain
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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. Related to log #000217:

Review of the progress notes, physician orders and Medication Administration Records(MARS) for Resident #13 indicated on a specified date, the resident had an un-witnessed fall, resulting in minor tissue injury and mild pain. Five days later, the resident complained of increased pain and decreased Range of Motion (ROM) to a specified area. The resident was assessed by the Nurse Practitioner (NP) and ordered increased analgesia and diagnostic imaging of the specified area if pain persisted. The RN indicated the increased analgesic was not available and the resident did not receive the analgesic as ordered for a period of two days. Seven days later, the resident was assessed again by the NP and due to continued complaints of pain, ordered the diagnostic imaging again, and added additional analgesic. The resident did not receive the additional analgesic until the following day and the resident had still not received the diagnostic imaging for two more days despite continued complaints of pain.
Review of the care plan (in place at time of incident) for Resident #13 did not include pain to the specified location related to a fall. The interventions included completing pain assessments to monitor effectiveness of pain control, administering pain medication as per MD orders and note the effectiveness, give PRN meds for breakthrough as per MD orders and note the effectiveness, monitor non-verbal signs and symptoms of pain, using pain scale of 1-10 and establish an acceptable baseline for comfort; and contact MD if pain not controlled.

Review of the homes policy "Pain Assessment" (reviewed April 2010) indicated the electronic "Pain Assessment Tool" is to be used when a new pain medication is initiated, the resident has new onset of pain, a resident complains of pain of 4 or greater or has facial grimacing. The "Pain Management Flow Sheet" is to be used when a scheduled pain medication does not relieve the pain or when pain remains regardless of interventions.

Review of pain assessments for Resident #13 indicated there was no documented evidence of a "Pain Management Flow Sheet" completed and the electronic "Pain Assessment Tool" was not completed until 7 days after the resident complained of pain unrelieved, and had two new analgesic ordered.

Therefore, the licensee failed to ensure the plan of care was based on an assessment of the resident, and the needs and preferences of the resident related to pain. [s. 6. (2)]

2. Related to log #000217:

Review of progress notes for Resident #14 indicated on a specified dated, the resident was found with pain and an injury from an unknown cause. There was no further documentation until seven days later, when the resident was again assessed by nursing related to the injury and the resident continued to have pain with decreased range of motion to the area. The following day,the resident was again assessed by nursing for the same injuries and pain. There was no indication the physician was notified during that time period. The resident continued to complain of severe pain to the specified area of injury two months later,and a note was left for the physician to assess the resident. The resident continued to complain of pain to the area two months later after that, and there was still no indication the resident was assessed by the physician or analgesic provided related to the resident's injury and continued complaints of pain.

Review of the care plan (during that period)for Resident #14 had no indication of pain related to the new injury. The interventions included administering analgesics as per MD orders and note the effectiveness; give PRN meds for breakthrough as per MD orders and note effectiveness;acknowledge presence of pain and discomfort and report complaints of pain to registered staff;document/report complaints and non-verbal signs of pain.

Review of pain assessments for Resident #14 indicated there was no documented evidence of a "Pain Management Flow Sheet" completed during that period of time. Only two electronic Pain Assessment Tools were completed during that period of time and had no indication of pain related to the new injury. There were no other pain assessments completed despite the resident's new injury and complaints of pain for a six month period. The plan of care did not reflect the resident's pain related to the new injury and there was no indication the resident's pain was managed. Therefore, the licensee failed to ensure the plan of care was based on an assessment of the resident, and the needs and preferences of the resident related to pain.

Voluntary plan of corrective action(VPC) was issued under LTCHA, 2007, s. 6(2) during inspection #2013_220111_0023 on December 12, 2013. [s. 6. (2)]

3. Related to log #000217:

Interview of staff and review of the progress notes for Resident #14 indicated on five specified dates during a six month period, the resident was found with an injury of unknown cause, resulting in severe pain and swelling and the Substitute Decision Maker(SDM) was not provided an opportunity to fully participate at any time during that period, in the development and implementation of the resident's plan of care.

Furthermore, review of progress notes for Resident #14 during a two month period indicated the resident sustained two falls and there was no indication the SDM was notified.

Therefore, the Licensee failed to ensure the SDM for Resident #14 was provided an opportunity to participate fully in the development and implementation of the resident's plan of care related to pain and falls. [s. 6. (5)]

4. Related to log ##000217:

Review of the progress notes for Resident#13 indicated on a specified date,the resident had an un-witnessed fall and sustained a tissue injury and complained of mild pain. Five days later, the resident continued to complain of pain, stiffness and decreased Range of Motion (ROM) to the same area which had been bothering the resident since the fall. The Nurse Practitioner (NP) assessed the resident, ordered a narcotic analgesic four times daily for 2 weeks, then decrease to a lower dosage of narcotic analgesic four times daily and complete diagnostic imaging of the area if the

pain continued. The RN indicated the narcotic analgesic was not available, and to use the lower dosage analgesic "until meds arrive". The narcotic analgesic was not started for three days. Five days later, the resident was assessed again by the NP who indicated "resident continues to complain of pain" to the specified area and again ordered the diagnostic imaging. The NP ordered an additional narcotic analgesic for pain indicating the initial narcotic analgesic ordered was "mildly effective". The SDM was contacted on this date regarding the order for the diagnostic imaging to be completed and the SDM expressed "upset they were not notified of fall".

There was no indication the SDM was notified that the resident sustained a fall on a specified date, or when the resident developed increased pain as a result of the fall five days later,or when new analgesics and treatments were ordered. The SDM was not notified until 10 days later when the resident was assessed a second time by the NP and ordered additional analgesic and diagnostic imaging. Therefore, the Licensee failed to ensure the SDM for Resident #13 was provided an opportunity to participate fully in the development and implementation of the resident's plan of care related to pain and falls. [s. 6. (5)]

5. Related to log #000217:

Review of progress notes and incident reports for Resident #14 indicated on a specified date, the resident sustained an unwitnessed fall. Approximately one month later, the resident sustained a second unwitnessed fall. Approximately one month later, the resident sustained a third unwitnessed fall. During this fall, staff heard the resident's chair alarm going off and found the resident on the floor and a "code care" was called.

Review of the care plan (in place at the time of falls) for Resident #14 indicated the resident was at risk of falls due to history of falls/injury, inability to transfer self, and forgets to call for assistance. Interventions included: routine nightly safety checks, use of 2 side rails in bed and bed in lowest position; in event of fall, staff to call "code care" and multidisciplinary team to review and revise interventions; uses bed/chair alarm and ensure alarm is in place; check 1 hr for safety, especially when in room; call bell within reach and strongly encourage resident to use call bell.

There was no indication the chair alarm was in use and a "code care" was called when the resident sustained the first two falls. There was also no indication when the resident sustained the first two falls, a multidisciplinary team review was completed

until the third fall occurred as a multidisciplinary "Post Falls Investigation Form" was completed. Therefore, the licensee failed to ensure the plan of care was provided to the resident as indicated in the plan related to falls.

Noncompliance was issued under LTCHA, 2007, s. 6(7) during inspection #2013_179103_0008 on February 3, 2013, during inspection#2013_049143_0035 on June 19, 2013, and during inspection #2013_220111_0023 on December 12, 2013. [s. 6. (7)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: 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. Related to Log #000243:

The licensee failed to protect Resident #5 from sexual abuse by Resident #4.

Under the O.Reg.79/10, s.2(1) For the purpose of the definition of "abuse" in subsection 2(1) of the Act,"sexual abuse" means, (b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A Critical Incident Report was received by the Director on a specified date for an incident of resident to resident sexual abuse that occurred five days earlier. The CI indicated Staff #106 reported witnessing Resident #4 sexually abusive towards Resident #5. Staff #101 and #100 intervened and both residents where immediately separated.

A review of the progress notes for Resident #4 indicated on a specified date, Staff #106 witnessed Resident #4 engaging in sexual abuse towards Resident #5 in Resident #4 room. Staff #101 and #100 intervened and both residents where immediately separated. Both nine and ten days later, Resident #4 was witnessed again engaged in sexually abusive behaviour towards Resident #5. Approximately one month later (on two consecutive days), Resident#4 was witnessed "seeking out" Resident#5. Approximately 3 weeks later, Resident #4 was witnessed on two separate occasions, attempting to remove Resident #5's articles of clothing. Two days later, Resident #4 was again witnessed "seeking out" Resident #5.

Interviews of Staff #106, Staff #102, and Staff #104 regarding how the home was protecting Resident #5 from further sexual abuse from Resident #4 indicated the two residents are "constantly watched" and redirected to ensure Resident #4 does not come into close proximity to Resident #5. Interview with Staff #111 reported witnessing Resident #4 recently sexually abusive towards Resident #5 but this incident was not documented or reported.

A review of the plan of care (current) for Resident #4 indicated the resident had mild dementia and ambulated independently about the unit. The resident had responsive behaviour of "socially not appropriate unwanted sexual touching" towards Resident #5 and the only strategies identified for preventing further sexual abuse towards Resident #5 were "monitoring" & "constant monitoring" of Resident #4 and #5 and "waiting for Ontario Shores to assess". This was despite a referral that was completed from Ontario Shores (completed four months prior) and provided specific recommendations to manage the Resident #4 sexually abusive responsive behaviouos towards Resident #5.

None of the recommendations from Ontario Shores were included in the written Plan of Care for Resident #4 or #5 and there was no documented evidence to support who, when and how frequently both residents were to be monitored.

Review of the health records for Resident #5 indicated the resident was cognitively impaired which was characterized by "aimless wandering about the unit via wheelchair", and had decreased speech and understanding which supports the resident's inability to provide consent.

Therefore, the licensee failed to protect Resident #5 from sexual abuse by Resident #4 as:

-the responsive behaviours of sexual abuse by Resident #4 towards Resident #5 continued, and there was no clear strategies identified, recommendations provided by Ontario Shores were not implemented, and there were no actions taken for Resident #5 on how they would protect the resident from Resident #4[issued under O.Reg.79/10, s.53(4)(b)(c)].
-when staff had reasonable grounds to suspect sexual abuse had occurred, failed to follow the homes policy on Prevention of Abuse and Neglect[issued under LTCHA, 2007, s.20(1)].
-the SDM of Resident#5 was not notified of the incidents of resident to resident sexual abuse, other than the incident that occurred on a specified date that was reported to the Director[issued under O.Reg. 79/10, s.97(1)(a)].
-the abusive behaviours that occurred on a specified date were not reported to the Director for a period of five days and the abusive behaviours that occurred on three other dates were never reported to the Director[issued under LTCHA, 2007, s.24]. (571)

2. Related to log #000217:

The licensee failed to protect Resident #14 from neglect.

Under the O.Reg.79/10, s.5 For the purposes of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Review of progress notes for Resident #14 indicated on a specified date, a PSW reported the resident had sustained an injury of unknown cause. The resident was not aware of how it occurred but stated it "is very sore". There was no further documentation until seven days later, when another PSW reported the same injury which had worsened and the resident "winced when touched" and stated "it hurts, please, handle with care". The following day, another RPN assessed the resident's injury (which remained unchanged) and the resident continued to "complains of mild pain on touching". There was no indication the physician was notified on any of those dates. The first indication the physician was notified was approximately 3 months later when the resident continued to "having increased +++pain" to the specified area and a note was left in the physicians book. Review of the physicians progress notes during that 3 month period indicated "stable, no concerns".Approximately one month later,a PSW requested the resident be assessed for the same injured area as the resident

was "resistive to using the sit to stand lift for sometime now due to +++ complaints of pain" in that area.

Interview of the Administrator indicated there was no documented evidence of an investigation into the injury of unknown cause for Resident #14 that occurred. Interview of the RCC indicated that the staff who documented on the initial two dates no longer worked in the home. Interview of the registered nursing staff member who documented on the third date, indicated they did not notify the physician or SDM "but would have passed it on to day shift" for follow-up. Interview of the registered nursing staff member who documented approximately three months later indicated " I left a note in the doctors book".

Review of the pain assessments completed indicated only electronic "Pain Assessment Tools" were completed approximately three weeks after the injury was noted and indicated the resident complained of pain to another specified area but no pain currently. A second "Pain Assessment Tool" was completed approximately three months later and again indicated pain to another specified area but no pain currently.There were no other pain assessments completed.

Review of the Medication Administration Records (MARS) indicated during the five month period that the resident complained of pain to the injured area, there was no change in the residents analgesics and analgesic that was ordered for breakthrough pain was only utilized x 2 during that time period (not on the days the resident actually complained of pain to the injured area).

Therefore, the licensee failed to protect Resident #14 from neglect due to a pattern of inaction as demonstrated by:
-there was no indication analgesics were provided to manage the resident's pain for a five month period, and no indication the physician was notified until approximately 3 months later, despite sustaining an injury of unknown cause to a specified area, and resulting in +++pain. Therefore, the licensee failed to ensure the plan of care was based on an assessment of the resident, and the needs and preferences of the resident related to pain[issued under LTCHA, 2007, s.6(2)]
-there was no indication when the resident developed new pain related to an injury of unknown cause to a specified area, the resident was assessed using a clinically appropriate assessment specifically designed for this purpose[issued under O.Reg. 79/10, s.52(2)].
-the SDM was not provided an opportunity to fully participate (on any of those dates)

in the development and implementation of the resident's plan of care[issued under LTCHA, 2007, s.6(5)].

A Compliance Order under LTCHA, 2007, s.19 was issued during inspection #2013_220111_0009 on June 6, 2013 and again during inspection #2013_220111_0023 on December 12, 2013.(571) [s. 19. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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. (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. Related to log #000107:

Review of the homes policy "Abuse & Neglect-Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff" (reviewed March 2014) indicated that "physical abuse" is any kind of physical assault such as slapping, pushing, pinching, kicking, punching or injury by an object or weapon.
Under Investigating & Responding to alleged, suspected or witnessed abuse or neglect of resident indicated:
-an employee witnessing an abusive event that they cannot diffuse by themselves can alert their fellow employees with a call of "code white" over the paging system.
Under Resident to Resident Abuse:
-any staff witnessing an alleged/actual act of abuse must report it to their immediate supervisor, ensure the immediate needs to the resident(s) are attended to and provide medical treatments as needed.
-the DON or Charge Nurse (if management not on site) will notify each resident's family member/POA and attending physician of the incident.

-the DON will interview both residents involved (if appropriate) to determine the cause of the behaviour, evaluating the events proceeding the incident and to complete the "Internal Incident Report Form". The form will then be forwarded to the interdisciplinary team conference for review, and evaluated for implementation of future preventative measures.

Review of the progress notes of Resident #3(during a one month period) indicated Resident #3 demonstrated 7 different incidents of physically aggressive responsive behaviours towards Resident #2, #4, and #17, and towards 5 other unidentified residents. Resident #3 also had one incident of physical abuse towards Resident #2 during that same period.

There was no indication the physician was notified of any of the incidents of resident to resident physical aggression (except for the incident of resident to resident physical abuse that was reported to the Director).
There was no indication the 5 unknown residents or Resident #2, #6, & #17 were assessed and care provided after incidents of physical aggression from Resident #3.
There was no indication when the staff were unable to manage the physically aggressive responsive behaviours of Resident #3 on two separate occasions, that a code white was called.
There was no indication an interdisciplinary conference was completed to review and implementation of preventative measures to prevent future incidents was held until after the last incident that was reported to the Director.

Review of health record of Resident #6 had no documented evidence of the incident, or of an assessment or medical treatment provided to the resident. There was no indication the DON, physician or POA was notified.

The POA was notified of the first incident and then the last incident when a "message left for POA re: medication changes and recent incidents" approximately three weeks after.

Therefore, The licensee failed to ensure that the homes policy on Prevention of Abuse and Neglect was complied with.

Noncompliance was issued during inspection #2013_179103_0008 on February 3, 2013, and during inspection #2013_049143_0035 on June 19, 2013. [s. 20. (1)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: 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:

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. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. Related to Log #000243:

A review of Critical Incident Report received by the Director for an incident of resident to resident sexual abuse that occurred indicated that on a specified date, Staff #106 witnessed Resident #4 sexually abusive towards Resident #5. Staff #101 and #100 intervened and both residents where immediately separated.

Interview of the Resident Care Coordinator (RCC) indicated that a Critical Incident(CI) was completed on the date the incident occurred but was not submitted to the Director until five days later due to the home's practice of emailing the Caressant Care Regional Director of all CI's so they can be reviewed and revised as necessary prior to submitting to the Director. The Administrator also confirmed this is the practice.

This homes practice is not consistent with the home's policy on Prevention of Abuse or with the legislation which indicates anyone shall immediately report abuse of a resident by anyone to the Director.

Noncompliance was issued under LTCHA, 2007, s.24(1)during inspection #2012_043157_0004 on January 18, 2012, during inspection #2013_220111_0009 on June 6, 2013, and during inspection #2013_220111_0023 on December 12, 2013. [s. 24. (1)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

The licensee failed to ensure that when a resident demonstrated responsive behaviours, strategies were developed and implemented to respond to these behaviours, where possible.

Related to Log# 000243:

A review of the health records for Resident #4 and Resident #5 indicated on a specified date, staff witnessed sexual abuse from Resident #4 towards Resident #5. Staff #101 and #100 intervened and both residents where immediately separated. Nine and ten days later, staff again witnessed sexual abuse between Resident #4 & #5 again. Approximately two months later, Resident #4 was seen trying to remove Resident #5's articles of clothing on two separate occasions. On three separate dates, Resident #4 was observed seeking out Resident #5.

Interviews of Staff #106, Staff #102, and Staff #104 indicated that the intervention used to prevent further sexual abuse between the two residents was to constantly watch and redirect Resident #5 if Resident #4 came into close proximity.Staff #111 indicated that they recently witnessed Resident #4 pushing Resident #5 in the mobility device and then kiss the resident. This incident was not documented.

A review of Resident #4 and Resident #5's plan of care indicates that the only strategies identified for direct care staff after Resident #4 sexually abused Resident #5 on a specified date and following ongoing sexually inappropriate behaviours were "monitoring & constant monitoring" of Resident #4 and #5 and "waiting for Ontario Shores to assess".

Review of the assessment from the external specialzed services indicated 3 recommendations that were not included in Resident #4's written Plan of Care.

A review of the progress notes for Resident #4 and Resident #5 (during the five month period)had no documented evidence to support when and how frequently both residents were monitored. [s. 53. (4) (b)]

2. Related to log #000107:

A critical incident report was submitted on a specified date indicating that 2 days prior, an incident of resident to resident physical abuse from Resident #3 towards Resident #2 resulting in Resident #2 sustaining pain and an injury.

Review of the progress notes of Resident #3(during a one month period) indicated Resident #3 demonstrated 7 different incidents of physically aggressive responsive behaviours towards Resident #2, #4, and #17, and towards 5 other unidentified residents. Resident #3 also had one incident of physical abuse towards Resident #2 during that same period.Interventions included administering psychotropic medications and redirection. Approximately three weeks later during that same month, a care conference was held to "review and revise the care plan due to behavioural issues" and the physician was contacted for a referral to Ontario Shores. Two days later, the resident was assessed by the NP for changes to medications and a referral for Ontario Shores was received.

Review of the plan of care (in place during that time) for Resident #3 related to responsive behaviours indicated:
-verbal/physical aggression, agitation/frustration, wanders into other residents rooms,can become agitated and aggressive when entering other residents rooms and with redirection, has difficulty expressing self, resistive to care/treatment and repetitive actions due to cognitive impairment, and behaviours are unpredictable and without provocation.
-Interventions included:documented summary of each episode noting cause and successful interventions; suspect UTI and dip urine and report results to MD; if strategies not working, leave and ensure safety of other residents and re-approach in 10 minutes; administer psychotropic medications as ordered by MD; use 2 staff at all times for care and redirection, illicit family input for best approaches to care, if the resident will not leave a co-residents room-remove the co-resident to prevent further escalation; and give an item or task to distract or break repetitive action.

There was no indication that when Resident#3 demonstrated ongoing responsive behaviours of physical aggression and abuse towards other residents, strategies were developed and implemented to respond to these behaviours, where possible.

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident's pain is not relived by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Related to log# 000217:

Review of the progress notes, physician orders and medication administration records for Resident #13 indicated on a specified date, the resident sustained an unwitnessed fall resulting in a tissue injury and mild pain to a specified area. Five days later, the resident continued to complain of pain, stiffness and decreased Range of Motion (ROM) tot he specified area. The Nurse Practitioner (NP) assessed the resident and ordered increased analgesic and diagnostic imaging if the pain persisted. The resident did not receive the increased analgesic for a period of 2 days and did not receive any analgesic for one of the two days Five days later, the resident was assessed again by the NP for continued complaints of pain to the specified area, ordered an additional anaglesic and ordered the diagnostic imaging again. The additional analgesic was not administered until the following day and the the resident had still not received diagnostic imaging despite continued complaints of pain until two days after that.

Interview of DOC indicated the emergency box contains Tylenol #3 for staff use when new orders are received.

Review of the homes policy "Pain Assessment" (reviewed April 2010) indicated the "Caressant Care Pain Assessment Tool" on Point Click Care(PCC) will be utilized when a new pain medication is initiated, a resident exhibits behaviour that may herald the onset of pain, a resident complains of pain of 4 or greater or facial grimace. The "Pain Management Flow Sheet" will be utilized when a scheduled pain medication does not relieve the pain or when pain remains regardless of interventions.

Review of the health care record of Resident #13 indicated no documented evidence of a Pain Management Flow Sheet when the resident sustained new pain from a fall and continued to complain of pain. The Pain Assessment on PCC was not completed until seven days after the the fall, despite continued complaints of pain and two new analgesic ordered.[s. 52. (2)]

2. Related to log #000217:

Review of progress notes for Resident #14 indicated on a specified date, a PSW reported the resident had sustained an injury of unknown cause. The resident was not aware of how it occurred but stated it "is very sore". There was no further documentation until seven days later, when another PSW reported the same injury which had worsened and the resident "winced when touched" and stated "it hurts, please, handle with care". The following day, another RPN assessed the resident's injury (which remained unchanged) and the resident continued to "complains of mild pain on touching". There was no indication the physician was notified on any of those dates. The first indication the physician was notified was approximately 3 months later when the resident continued to "having increased +++pain" to the specified area and a note was left in the physicians book. Review of the physicians progress notes during that 3 month period indicated "stable, no concerns".Approximately one month later,a PSW requested the resident be assessed for the same injured area as the resident was "resistive to using the sit to stand lift for sometime now due to +++ complaints of pain" in that area.

Review of the pain assessments indicated only electronic Pain Assessment Tools were completed three weeks after the injury was noted, indicating pain in a different location but no pain currently. A second electronic pain assessment was completed

approximately 3 months later again indicating pain in a different location but no pain currently. There were no other pain assessments completed.

There was no indication when the resident developed pain related to an injury of unknown cause to a specified area, the resident was assessed using a clinically appropriate assessment specifically designed for this purpose. [s. 52. (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 when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
1. A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident. O. Reg. 79/10, s. 104 (1).

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written report to the Director for a witnessed incident of resident to resident physical abuse, included a description of the individuals involved in the incident and the events leading up to the incident.

Related to log #000107:

A critical incident report was submitted on a specified date for an incident of resident to resident physical abuse that occurred two days prior to submission. The CI description indicated the recipient of the aggression sustained an injury. The full names of the residents involved in the incident were not provided and a request by the Director requesting more information of the events leading up to the incident was not provided.

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 when the Director is notified in writing of any alleged, suspected or witnessed incidents of abuse and neglect of a resident, the description of the individuals involved in the incident is included, and the events leading up to the incident, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 55. Behaviours and altercations
Every licensee of a long-term care home shall ensure that,
(a) procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents; and
(b) all direct care staff are advised at the beginning of every shift of each resident whose behaviours, including responsive behaviours, require heightened monitoring because those behaviours pose a potential risk to the resident or others. O. Reg. 79/10, s. 55.

Findings/Faits saillants :

The licensee failed to ensure that procedures and interventions are developed and implemented to assist residents and staff who are at risk of harm or who are harmed as a result of a resident's behaviours, including responsive behaviours, and to minimize the risk of altercations and potentially harmful interactions between and among residents.

Related to log#000107:

Review of the homes policy "Responsive Behaviour Management" (reviewed May 2014) indicated under procedures:
-identify the trigger of the responsive behaviour,
-include the interventions to prevent, address and de-escalate behaviours using resident focused goals and strategies which help to ensure the general well-being and quality of life of the resident.
-develop a plan of care that identifies the trigger of the behaviour and the strategies to effectively manage them.

Interview of the BSO (Behaviour Supports Ontario) team leads (RPN#100 & PSW#107) indicated that they both work full time in the home at varied times, complete daily reviews on each unit of any residents demonstrating responsive behaviours or behaviours that have been reported to BSO Team; They put in place assessment tools(DOS, BAT)for the residents to be completed by nursing staff to determine behaviours/patterns; They review the assessments, complete a crisis care plan that identifies the behaviours/triggers/and interventions to manage the behaviours; They meet weekly with the NP to discuss behaviours but do not keep minutes of the their meetings; The behaviours/triggers/interventions are also placed on the white BSO boards located on each unit and in a binder on each unit for staff;They also notify the RAI Coordinator who updates the care plans on Point click care; They prepare information for referrals to Ontario Shores and spend time with residents who are demonstrating responsive behaviours (when possible); They indicated the BSO team has "only been up and running for the last two months".

There was no indication in the homes policy of "Responsive Behaviours" referencing the use of a BSO team, or the use of referrals to NP, or referrals to Ontario Shores.

WN #9: 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 :

The licensee failed to ensure that the Director was informed, no later than one business day, of a resident who was missing for less than three hours and who returned to the home with no injury or adverse change in condition.

A review of the clinical records for Resident #16 indicated on a specified date, Resident #16 was discovered outside the home, attempting to re-enter the home. The resident was not dressed appropriately for seasonal conditions and did not have a required treatment in place. The resident had been missing for approximately 10 minutes.

An interview with the RCC indicated the incident was not reported to the Director.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to a resident in accordance with the directions for use specified by the prescriber.

Related to log 000217:

Review of the progress notes, physicians orders, and Medication Administration Record (MAR) for Resident# 13 indicated the resident sustained an unwitnessed fall resulting in tissue injury to a specified area and pain. Five days later, the resident was assessed by the Nurse Practitioner (NP) for complaints of increased pain and decreased range of motion to the specified area. The NP ordered increased analgesics and diagnostic imaging if pain persisted. The increased analgesic was not administered for a two day period, (and the resident did not receive any analgesic for one of those days) and the diagnostic imaging was not completed. Five days after that, the NP assessed the resident again for continued complaints of pain to the specified area, and ordered additional analgesia and to complete the diagnostic imaging. The second analgesic ordered was not provided until the following day and the diagnostic imaging was not completed for two more days.

Interview of the DOC indicated that the home has the ordered analgesics available in the emergency drug box. [s. 131. (2)]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S)
REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 23. (1)	CO #001	2013_220111_0009	111
O.Reg 79/10 s. 9.	WN	2013_178102_0029	111
O.Reg 79/10 s. 98.	CO #003	2013_220111_0023	111

Issued on this 26th day of August, 2014

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LYNDA BROWN (111), PATRICIA BELL (571)
Inspection No. / No de l'inspection :	2014_360111_0018
Log No. / Registre no:	O-000081-14
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jul 31, 2014
Licensee / Titulaire de permis :	CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED 264 NORWICH AVENUE, WOODSTOCK, ON, N4S-3V9
LTC Home / Foyer de SLD :	CARESSANT CARE ON MCLAUGHLIN ROAD 114 McLaughlin Road, LINDSAY, ON, K9V-6L1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Paul Ludgate

To CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee is hereby ordered to prepare, submit and implement a plan to include the following:
-review and revise the plan of care for Resident #13 & #14, and any other resident at moderate to high risk for falls, to ensure the plan of care and the interventions to mitigate the risk of falls.
-all direct care staff to complete a mandatory and comprehensive education session offered in various formats to meet the learning needs of adult learners on prevention of falls.
-the plan shall also include a process on how the home will measure the effectiveness of the education to ensure compliance is maintained and the actions the home will take if
noncompliance is identified.

The plan shall be submitted in writing by fax to Inspector, Lynda Brown at 905 -433-3013 on or before August 11, 2014. The plan shall identify who will be responsible for each of the corrective actions listed.

Grounds / Motifs :

1. . (111)

2. Related to log #000217:

Review of progress notes and incident reports for Resident #14 indicated on a specified date, the resident sustained an unwitnessed fall. Approximately one month later, the resident sustained a second unwitnessed fall. Approximately one month later, the resident sustained a third unwitnessed fall. During this fall, staff heard the resident's chair alarm going off and found the resident on the floor and a "code care" was called.

Review of the care plan (in place at the time of falls) for Resident #14 indicated the resident was at risk of falls due to history of falls/injury, inability to transfer self, and forgets to call for assistance. Interventions included: routine nightly safety checks, use of 2 side rails in bed and bed in lowest position; in event of fall, staff to call "code care" and multidisciplinary team to review and revise interventions; uses bed/chair alarm and ensure alarm is in place; check 1 hr for safety, especially when in room; call bell within reach and strongly encourage resident to use call bell.

There was no indication the chair alarm was in use and a "code care" was called when the resident sustained the first two falls. There was also no indication when the resident sustained the first two falls, a multidisciplinary team review was completed until the third fall occurred as a multidisciplinary "Post Falls Investigation Form" was completed. Therefore, the licensee failed to ensure the plan of care was provided to the resident as indicated in the plan related to falls.

Noncompliance was issued under LTCHA, 2007, s. 6(7) during inspection #2013_179103_0008 on February 3, 2013, during inspection#2013_049143_0035 on June 19, 2013, and during inspection #2013_220111_0023 on December 12, 2013. [s. 6. (7)] (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 01, 2014

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2013_220111_0023, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee is hereby ordered to prepare, submit and implement a plan to include the following:
-all direct care staff to complete a mandatory and comprehensive education session offered in various formats to meet the learning needs of adult learners on all forms of abuse and neglect.
The education should include but not be limited to:
-how to identify all forms of resident abuse and neglect as defined by the O. Regs 79/10
s. 2,
-the difference between consensual and non-consensual sexual touching with a focus on residents that have a cognitive impairment,
-the mandatory reporting obligations by anyone as outlined in the LTCHA, 2007 s. 24 to
immediately report all alleged, suspected or witnessed incidents of abuse and neglect to the Director,
-how to use of the Abuse Decision Trees by the Ministry of health and Long Term Care, to assist in the decision to report and investigate allegations, suspicions or witnessed incidents of resident abuse or neglect,
-the legislated reporting requirements for the notification of the resident's substitute decision maker in accordance with O. Regs 79/10 s. 97,
-the legislated reporting requirements for the notification of the police in accordance with O. Regs 79/10, s. 98.
-the plan shall also include how the home will monitor the effectiveness of the education to ensure compliance and the actions the home will take if noncompliance is identified.

The plan shall be submitted in writing by fax to Inspector, Lynda Brown at 905 -433-3013 on or before August 11, 2014. The plan shall identify who will be responsible for each of the corrective actions listed.

Grounds / Motifs :

1. 1. Related to Log #000243:

The licensee failed to protect Resident #5 from sexual abuse by Resident #4.

Under the O.Reg.79/10, s.2(1) For the purpose of the definition of "abuse" in subsection 2(1) of the Act,"sexual abuse" means, (b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A Critical Incident Report was received by the Director on a specified date for an incident of resident to resident sexual abuse that occurred five days earlier. The CI indicated Staff #106 reported witnessing Resident #4 sexually abusive towards Resident #5. Staff #101 and #100 intervened and both residents where immediately separated.

A review of the progress notes for Resident #4 indicated on a specified date, Staff #106 witnessed Resident #4 engaging in sexual abuse towards Resident #5 in Resident #4 room. Staff #101 and #100 intervened and both residents where immediately separated. Both nine and ten days later, Resident #4 was witnessed again engaged in sexually abusive behaviour towards Resident #5. Approximately one month later (on two consecutive days), Resident#4 was witnessed "seeking out" Resident#5. Approximately 3 weeks later, Resident #4 was witnessed on two separate occasions, attempting to remove Resident #5's articles of clothing. Two days later, Resident #4 was again witnessed "seeking out" Resident #5.

Interviews of Staff #106, Staff #102, and Staff #104 regarding how the home was protecting Resident #5 from further sexual abuse from Resident #4 indicated the two residents are "constantly watched" and redirected to ensure Resident #4 does not come into close proximity to Resident #5. Interview with Staff #111 reported witnessing Resident #4 recently sexually abusive towards Resident #5 but this incident was not documented or reported.

A review of the plan of care (current) for Resident #4 indicated the resident had mild dementia and ambulated independently about the unit. The resident had responsive behaviour of "socially not appropriate unwanted sexual touching" towards Resident #5 and the only strategies identified for preventing further sexual abuse towards Resident #5 were "monitoring" & "constant monitoring" of Resident #4 and #5 and "waiting for Ontario Shores to assess". This was despite a referral that was completed from Ontario Shores (completed four months prior) and provided specific recommendations to manage the Resident #4 sexually abusive responsive behaviouos towards Resident #5.

None of the recommendations from Ontario Shores were included in the written Plan of Care for Resident #4 or #5 and there was no documented evidence to support who, when and how frequently both residents were to be monitored.

Review of the health records for Resident #5 indicated the resident was cognitively impaired which was characterized by "aimless wandering about the unit via wheelchair", and had decreased speech and understanding which supports the resident's inability to provide consent.

Therefore, the licensee failed to protect Resident #5 from sexual abuse by Resident #4 as:
-the responsive behaviours of sexual abuse by Resident #4 towards Resident #5 continued, and there was no clear strategies identified, recommendations provided by Ontario Shores were not implemented, and there were no actions taken for Resident #5 on how they would protect the resident from Resident #4[issued under O.Reg.79/10, s.53(4)(b)(c)].
-when staff had reasonable grounds to suspect sexual abuse had occurred, failed to follow the homes policy on Prevention of Abuse and Neglect[issued under LTCHA, 2007, s.20(1)].
-the SDM of Resident#5 was not notified of the incidents of resident to resident sexual abuse, other than the incident that occurred on a specified date that was reported to the Director[issued under O.Reg. 79/10, s.97(1)(a)].
-the abusive behaviours that occurred on a specified date were not reported to the Director for a period of five days and the abusive behaviours that occurred on three other dates were never reported to the Director[issued under LTCHA, 2007, s.24].(571)

2. Related to log #000217:

The licensee failed to protect Resident #14 from neglect.

Under the O.Reg.79/10, s.5 For the purposes of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Review of progress notes for Resident #14 indicated on a specified date, a PSW reported the resident had sustained an injury of unknown cause. The resident was not aware of how it occurred but stated it "is very sore". There was no further documentation until seven days later, when another PSW reported the same injury which had worsened and the resident "winced when touched" and stated "it hurts, please, handle with care". The following day, another RPN

assessed the resident's injury (which remained unchanged) and the resident continued to "complains of mild pain on touching". There was no indication the physician was notified on any of those dates. The first indication the physician was notified was approximately 3 months later when the resident continued to "having increased +++pain" to the specified area and a note was left in the physicians book. Review of the physicians progress notes during that 3 month period indicated "stable, no concerns".Approximately one month later,a PSW requested the resident be assessed for the same injured area as the resident was "resistive to using the sit to stand lift for sometime now due to +++ complaints of pain" in that area.

Interview of the Administrator indicated there was no documented evidence of an investigation into the injury of unknown cause for Resident #14 that occurred. Interview of the RCC indicated that the staff who documented on the initial two dates no longer worked in the home. Interview of the registered nursing staff member who documented on the third date, indicated they did not notify the physician or SDM "but would have passed it on to day shift" for follow-up. Interview of the registered nursing staff member who documented approximately three months later indicated " I left a note in the doctors book".

Review of the pain assessments completed indicated only electronic "Pain Assessment Tools" were completed approximately three weeks after the injury was noted and indicated the resident complained of pain to another specified area but no pain currently. A second "Pain Assessment Tool" was completed approximately three months later and again indicated pain to another specified area but no pain currently.There were no other pain assessments completed.

Review of the Medication Administration Records (MARS) indicated during the five month period that the resident complained of pain to the injured area, there was no change in the residents analgesics and analgesic that was ordered for breakthrough pain was only utilized x 2 during that time period (not on the days the resident actually complained of pain to the injured area).

Therefore, the licensee failed to protect Resident #14 from neglect due to a pattern of inaction as demonstrated by:
-there was no indication analgesics were provided to manage the resident's pain for a five month period, and no indication the physician was notified until approximately 3 months later, despite sustaining an injury of unknown cause to a specified area, and resulting in +++pain. Therefore, the licensee failed to

ensure the plan of care was based on an assessment of the resident, and the needs and preferences of the resident related to pain[issued under LTCHA, 2007, s.6(2)]
-there was no indication when the resident developed new pain related to an injury of unknown cause to a specified area, the resident was assessed using a clinically appropriate assessment specifically designed for this purpose[issued under O.Reg. 79/10, s.52(2)].
-the SDM was not provided an opportunity to fully participate (on any of those dates) in the development and implementation of the resident's plan of care [issued under LTCHA, 2007, s.6(5)].

A Compliance Order under LTCHA, 2007, s.19 was issued during inspection #2013_220111_0009 on June 6, 2013 and again during inspection #2013_220111_0023 on December 12, 2013.(571) [s. 19. (1)] (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 01, 2014

Order # / Ordre no : 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that all management staff, including Registered Nurses, all Department Managers, Resident Care Coordinator, Director of Care, the Administrator and anyone else delegated as the supervisor of the home, receives further training to include but not limited to:
-reporting obligations of a person who has reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or risk of harm to the resident to immediately report to the Director (LTCHA, 2007 s. 24),
-Notification of substitute decision makers of an alleged, suspected or witnessed incident of abuse (O. Regs 79/10 s. 97),
- Police notification of an alleged, suspected or witnessed incident of abuse (O. Regs 79/10 s. 98),
- to conduct an investigation into every alleged, suspected or witnessed incident of abuse of a resident by anyone (LTCHA, 2007 s. 23), and how to complete the related documentation to the investigation, as per the home's policy of prevention of abuse (O. Regs 79/10, s.20) and using the results of the investigations to undertake an assessment the effectiveness of actions and continuous improvements.
- the home shall also develop a process for the ongoing monitoring of compliance.

The plan should be submitted in writing by fax to Inspector, Lynda Brown at fax # 905-433-3013, no later than August 11, 2014. The plan shall indicate who will be
responsible for ensuring the completion of the tasks.

Grounds / Motifs :

1. 1. Related to log #000107:

Review of the homes policy "Abuse & Neglect-Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff" (reviewed March 2014) indicated that "physical abuse" is any kind of physical assault such as slapping, pushing, pinching, kicking, punching or injury by an object or weapon.
Under Investigating & Responding to alleged, suspected or witnessed abuse or neglect of resident indicated:
-an employee witnessing an abusive event that they cannot diffuse by themselves can alert their fellow employees with a call of "code white" over the paging system.

Under Resident to Resident Abuse:
-any staff witnessing an alleged/actual act of abuse must report it to their immediate supervisor, ensure the immediate needs to the resident(s) are attended to and provide medical treatments as needed.
-the DON or Charge Nurse (if management not on site) will notify each resident's family member/POA and attending physician of the incident.
-the DON will interview both residents involved (if appropriate) to determine the cause of the behaviour, evaluating the events proceeding the incident and to complete the "Internal Incident Report Form". The form will then be forwarded to the interdisciplinary team conference for review, and evaluated for implementation of future preventative measures.

Review of the progress notes of Resident #3(during a one month period) indicated Resident #3 demonstrated 7 different incidents of physically aggressive responsive behaviours towards Resident #2, #4, and #17, and towards 5 other unidentified residents. Resident #3 also had one incident of physical abuse towards Resident #2 during that same period.

There was no indication the physician was notified of any of the incidents of resident to resident physical aggression (except for the incident of resident to resident physical abuse that was reported to the Director).
There was no indication the 5 unknown residents or Resident #2, #6, & #17 were assessed and care provided after incidents of physical aggression from Resident #3.
There was no indication when the staff were unable to manage the physically aggressive responsive behaviours of Resident #3 on two separate occasions, that a code white was called.
There was no indication an interdisciplinary conference was completed to review and implementation of preventative measures to prevent future incidents was held until after the last incident that was reported to the Director.

Review of health record of Resident #6 had no documented evidence of the incident, or of an assessment or medical treatment provided to the resident.
There was no indication the DON, physician or POA was notified.

The POA was notified of the first incident and then the last incident when a "message left for POA re: medication changes and recent incidents" approximately three weeks after.

Therefore, The licensee failed to ensure that the homes policy on Prevention of Abuse and Neglect was complied with.

Noncompliance was issued during inspection #2013_179103_0008 on February 3, 2013, and during inspection #2013_049143_0035 on June 19, 2013. [s. 20. (1)] (111)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 01, 2014

Order # / Ordre no : 004

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant:
2013_220111_0009, CO #002;
2013_220111_0023, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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, s. 24 (1), 195 (2).

Order / Ordre :

Refrain from practices that interfere with any person(s) who has reasonable grounds to suspect that 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.any of the following has occurred or may occur to ensure compliance with immediate reporting as per the home's policy of prevention of abuse and as per the legislative requirements under LTCHA, 2007, s.24. regarding reporting.

Grounds / Motifs :

1. 1. Related to Log #000243:

A review of Critical Incident Report received by the Director for an incident of resident to resident sexual abuse that occurred indicated that on a specified date, Staff #106 witnessed Resident #4 sexually abusive towards Resident #5. Staff #101 and #100 intervened and both residents where immediately separated.

Interview of the Resident Care Coordinator (RCC) indicated that a Critical Incident(CI) was completed on the date the incident occurred but was not submitted to the Director until five days later due to the home's practice of emailing the Caressant Care Regional Director of all CI's so they can be reviewed and revised as necessary prior to submitting to the Director. The Administrator also confirmed this is the practice.

This homes practice is not consistent with the home's policy on Prevention of Abuse or with the legislation which indicates anyone shall immediately report abuse of a resident by anyone to the Director.

Noncompliance was issued under LTCHA, 2007, s.24(1)during inspection #2012_043157_0004 on January 18, 2012, during inspection #2013_220111_0009 on June 6, 2013, and during inspection #2013_220111_0023 on December 12, 2013. [s. 24. (1)] (571)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 01, 2014

Order # / Ordre no : 005

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to include the following:
(a) A process to ensure that residents who demonstrate responsive behaviours which potentially lead to sexual abuse have a written plan of care that includes at a minimum:
- clear direction to staff and others who provide direct care to the resident
- is reassessed when the resident's care needs change and revised when interventions are ineffective
- identification of behavioural triggers
- documented strategies to respond to the resident's responsive behaviours
- documentation of the resident's responses to interventions
- actions to be taken to minimize the risk to the resident's who are the recipients of these responsive behaviours.
interactions between and among residents
(b) The revision of licensee's policies related to Responsive Behaviours to include:
- a structured process that includes how both the nursing staff and the BSO team (that is currently in place), will ensure the review and revision of the resident's plan of care who are exhibiting responsive behaviours (particularly physical /sexual abuse and elopement), will include the reassessment of the effectiveness of planned interventions, that appropriate actions are taken to manage the responsive behaviours, and any additional referrals to specialized services to assist in the management of resident's with responsive behaviours.
(c) Develop and implement a monitoring process to ensure the above is completed.
(d) Retrain all direct care staff on the home's revised Responsive Behaviours policy
(e)The plan shall also include how the home will measure the effectiveness of the
education to ensure sustained compliance and the actions the home will take if non compliance is identified.

The plan shall be submitted in writing by fax to Inspector, Lynda Brown at 905-433-3013 on or before August 11, 2014. The plan shall identify who will be responsible for each of the corrective actions listed.

Grounds / Motifs :

1. The licensee failed to ensure that when a resident demonstrated responsive behaviours, strategies were developed and implemented to respond to these

behaviours, where possible.

Related to Log# 000243:

A review of the health records for Resident #4 and Resident #5 indicated on a specified date, staff witnessed sexual abuse from Resident #4 towards Resident #5. Staff #101 and #100 intervened and both residents where immediately separated. Nine and ten days later, staff again witnessed sexual abuse between Resident #4 & #5 again. Approximately two months later, Resident #4 was seen trying to remove Resident #5's articles of clothing on two separate occasions. On three separate dates, Resident #4 was observed seeking out Resident #5.

Interviews of Staff #106, Staff #102, and Staff #104 indicated that the intervention used to prevent further sexual abuse between the two residents was to constantly watch and redirect Resident #5 if Resident #4 came into close proximity.Staff #111 indicated that they recently witnessed Resident #4 pushing Resident #5 in the mobility device and then kiss the resident. This incident was not documented.

A review of Resident #4 and Resident #5's plan of care indicates that the only strategies identified for direct care staff after Resident #4 sexually abused Resident #5 on a specified date and following ongoing sexually inappropriate behaviours were "monitoring & constant monitoring" of Resident #4 and #5 and "waiting for Ontario Shores to assess".

Review of the assessment from the external specialized services indicated 3 recommendations that were not included in Resident #4's written Plan of Care.

A review of the progress notes for Resident #4 and Resident #5 (during the five month period)had no documented evidence to support when and how frequently both residents were monitored. [s. 53. (4) (b)]

2. Related to log #000107:

A critical incident report was submitted on a specified date indicating that 2 days prior, an incident of resident to resident physical abuse from Resident #3 towards Resident #2 resulting in Resident #2 sustaining pain and an injury.

Review of the progress notes of Resident #3(during a one month period)

indicated Resident #3 demonstrated 7 different incidents of physically aggressive responsive behaviours towards Resident #2, #4, and #17, and towards 5 other unidentified residents. Resident #3 also had one incident of physical abuse towards Resident #2 during that same period.Interventions included administering psychotropic medications and redirection. Approximately three weeks later during that same month, a care conference was held to "review and revise the care plan due to behavioural issues" and the physician was contacted for a referral to Ontario Shores. Two days later, the resident was assessed by the NP for changes to medications and a referral for Ontario Shores was received.

Review of the plan of care (in place during that time) for Resident #3 related to responsive behaviours indicated:
-verbal/physical aggression, agitation/frustration, wanders into other residents rooms,can become agitated and aggressive when entering other residents rooms and with redirection, has difficulty expressing self, resistive to care/treatment and repetitive actions due to cognitive impairment, and behaviours are unpredictable and without provocation.
-Interventions included:documented summary of each episode noting cause and successful interventions; suspect UTI and dip urine and report results to MD; if strategies not working, leave and ensure safety of other residents and re-approach in 10 minutes; administer psychotropic medications as ordered by MD; use 2 staff at all times for care and redirection, illicit family input for best approaches to care, if the resident will not leave a co-residents room-remove the co-resident to prevent further escalation; and give an item or task to distract or break repetitive action.

There was no indication that when Resident#3 demonstrated ongoing responsive behaviours of physical aggression and abuse towards other residents, strategies were developed and implemented to respond to these behaviours, where possible. (571)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 01, 2014

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 31st day of July, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : LYNDA BROWN

Service Area Office /
Bureau régional de services : Ottawa Service Area Office