

FINAL INSPECTION REPORT
Under the *Retirement Homes Act, 2010*

Inspection Information

Date of Inspection: 11/9/2023

Name of Inspector: Shyla Sittampalam, RN

Inspection Type: Routine Inspection

Licensee: ACC-003130 - Caessant Care Nursing and Retirement Homes Limited

Retirement Home: Caessant Care - Lindsay

License Number: T0030

About Routine Inspections

A routine inspection, performed by an RHRA inspector, is a physical inspection of a licensed retirement home. During a routine inspection, an RHRA inspector will walk through the home, speak to residents and staff, observe care services and conditions in the home, and ensure the licensee's management and staff follow mandatory policies and practices designed to protect the welfare of residents.

Following a routine inspection, the RHRA inspector prepares a draft inspection report which is sent to the licensee. The draft report may include instances where the licensee has failed to meet the standards of the *RHA*. If included, the licensee can respond to these instances and is strongly encouraged to inform RHRA of its plans to meet the standards of the *RHA*.

Following the draft report, the RHRA inspector prepares this final inspection report, incorporating any response from the licensee with their plans to meet the standards of the *RHA*. The most recent final inspection report must be posted in the home in a visible and easily accessible location. All final inspection reports from the previous two years must also be made available in an easily accessible location in the home. The licensee must provide a copy of this report to the home's Residents' Council, if one exists.

In addition to inspection reports, RHRA may provide information to a licensee to encourage improvements of their current practices.

If the licensee repeatedly does not meet the required standards, RHRA may take further action.

Focus Areas

During a routine inspection, an inspector will focus primarily on a set number of areas which have been identified as related to the health, safety and wellbeing of resident, and may take various actions to determine whether the licensee is compliant with the RHA in relating to the areas. The areas listed in this section are ones which an inspector has identified as non-compliant.

Focus Area #1: Abuse and Neglect

RHRA Inspector Findings

The inspector found evidence through documentation in the home of two incidents of resident-to-resident abuse which had occurred and had not been reported to the RHRA. The Licensee failed to ensure the incidents were reported as required. Furthermore, after interviewing staff and reviewing resident care files, the inspector confirmed that the Licensee was aware of the incidents and failed to notify the residents' substitute decision makers and the local police services, and failed to conduct an investigation, as required by their zero tolerance of abuse policy. The Licensee did not ensure the incidents were investigated as required and did not fully implement their zero tolerance of abuse policy.

Outcome

The Licensee submitted a plan to achieve compliance by Fri Dec 22 2023. RHRA to confirm compliance by following up with the

Licensee or by inspection.

Focus Area #2: Behaviour Management

RHRA Inspector Findings

The inspector reviewed a sample of resident files and interviewed staff, the inspector found three residents who had exhibited behaviours that posed a risk to others in the home, the Licensee was unable to demonstrate implementation of any behaviour management strategies as set forth in their strategy. The Licensee failed to comply with the requirements as prescribed.

Outcome

The Licensee submitted a plan to achieve compliance by Fri Dec 01 2023. RHRA to confirm compliance by following up with the Licensee or by inspection.

Focus Area #3: Resident Record, Assessment, Plan of Care

RHRA Inspector Findings

The inspector reviewed a sample of resident care files and found that the Licensee failed to reassess two residents and review and revise their plans of care when their care needs changed. Furthermore, the inspector found that the plan of care for a resident who requires wound care did not include the planned care services provided by an external care provider including the details of the services and the goals. The Licensee failed to comply with the requirements as prescribed.

Outcome

The Licensee submitted a plan to achieve compliance by Fri Dec 22 2023. RHRA to confirm compliance by following up with the Licensee or by inspection.

Additional Findings

During a routine inspection, an inspector may observe areas of non-compliance that are not related to the standard focus areas. In these cases, an inspector may cite the home for these contraventions at the time of this inspection. In addition, an inspector may follow-up on findings of non-compliance from previous inspections. Where the licensee is unable to demonstrate they have come into compliance or maintained compliance, an inspector may cite the home for these repeat contraventions at the time of this inspection.

Not Applicable

Current Inspection – Citations

Citations relating to the above Focus Areas or Additional Findings made during the current inspection are listed below.

The Licensee failed to comply with the RHA s. 23. (1); Behaviour management

s. 23. (1); Behaviour management

23. (1) Every licensee of a retirement home shall develop and implement a written behaviour management strategy that includes,

Specifically, the Licensee failed to comply with the following subsection(s):

s. 23. (1), (a)

(a) techniques to prevent and address resident behaviours that pose a risk to the resident or others in the home;

s. 23. (1), (b)

(b) strategies for interventions to prevent and address resident behaviours that pose a risk to the resident or others in the home;

s. 23. (1), (c)

(c) strategies for monitoring residents that have demonstrated behaviours that pose a risk to the resident or others in the home.

The Licensee failed to comply with the RHA s. 62. (12); Reassessment and revision

s. 62. (12); Reassessment and revision

62. (12) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time if, in the opinion of the licensee or the resident,

Specifically, the Licensee failed to comply with the following subsection(s):

s. 62. (12), (b)

(b) the resident's care needs change or the care services set out in the plan are no longer necessary.

The Licensee failed to comply with the RHA s. 62. (4); Contents of plan

s. 62. (4); Contents of plan

62. (4) The licensee of a retirement home shall ensure that there is a written plan of care for each resident of the home that sets out,

Specifically, the Licensee failed to comply with the following subsection(s):

s. 62. (4), (c)

(c) if the resident has consented to the inclusion of the information in the plan of care, the planned care services for the resident that external care providers will provide with the consent of the resident, to the extent that such information is available to the licensee after the licensee has taken all reasonable steps to obtain such information from the resident and the external care provider, including,

s. 62. (4), (c), 1.

(i) the details of the services,

s. 62. (4), (c)

(c) if the resident has consented to the inclusion of the information in the plan of care, the planned care services for the resident that external care providers will provide with the consent of the resident, to the extent that such information is available to the licensee after the licensee has taken all reasonable steps to obtain such information from the resident and the external care provider, including,

s. 62. (4), (c), 2.

(ii) the goals that the services are intended to achieve.

The Licensee failed to comply with the RHA s. 67. (4); Policy to promote zero tolerance

s. 67. (4); Policy to promote zero tolerance

67. (4) Without in any way restricting the generality of the duties described in subsections (1) and (2), the licensee shall ensure that there is a written policy to promote zero tolerance of abuse and neglect of residents and shall ensure that the policy is complied with.

The Licensee failed to comply with the RHA s. 74.; Licensee's duty to respond to incidents of wrongdoing

s. 74.; Licensee's duty to respond to incidents of wrongdoing

74. Every licensee of a retirement home shall ensure that,

Specifically, the Licensee failed to comply with the following subsection(s):

s. 74. (a)

(a) every alleged, suspected or witnessed incident of the following of which the licensee knows or that is reported to the licensee is immediately investigated:

s. 74. (a), 1.

(i) abuse of a resident of the home by anyone,

The Licensee failed to comply with the RHA s. 75. (1); Reporting certain matters to Registrar

s. 75. (1); Reporting certain matters to Registrar

75. (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 Registrar:

Specifically, the Licensee failed to comply with the following subsection(s):

s. 75. (1), para. 2

2. Abuse of a resident by anyone or neglect of a resident by the licensee or the staff of the retirement home of the resident if it results in harm or a risk of harm to the resident.

Closed Citations

During an inspection, an inspector may follow-up with areas of non-compliance cited during a previous inspection, or verify compliance with areas initially cited during the current inspection. The inspector has verified that at the time of this report, the licensee was able to demonstrate that the following areas have come into compliance.

Not Applicable

NOTICE

The Final Inspection Report is being provided to the Licensee, the Registrar of the RHRA and the home's Residents' Council, if any.

Section 55 of the *RHA* requires that the Final Inspection Report be posted in the home in a conspicuous and easily accessible location. In addition, the Licensee must ensure that copies of every Final Inspection Report from the previous two (2) years are made available in the Home, in an easily accessible location.

The Registrar's copy of the Final Inspection Report, as it appears here, will be included on the RHRA Retirement Home Database available online at <http://www.rhra.ca/en/retirement-home-database>.

Signature of Inspector

Shyla Sittampalam, RN

Date

November 29, 2023