Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Ottawa Service Area Office
347 Preston St, 4th Floor
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Date(s) of inspection/Date(s) de l'inspection	Inspection No/ No de l'inspection	Type of Inspection/Genre d'inspection
Apr 12, 13, 16, 26, 27, 30, May 1, 2, 2012	2012_034117_0015	Critical Incident

Licensee/Titulaire de permis

CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE, WOODSTOCK, ON, N4S-3V9

Long-Term Care Home/Foyer de soins de longue durée

CARESSANT CARE BOURGET
2279 Laval Street, P.O. Box 99, Bourget, ON, K0A-1E0

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

LYNE DUCHESNE (117)

Inspection Summary/Résumé de l'inspection

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

During the course of the inspection, the inspector(s) spoke with the Regional Manager, the Administrator, the Director of Care (DOC), several Registered Nurses (RN), a Registered Practical Nurse (RPN), several Personal Support Workers (PSW),a housekeeper, an activity aide co-op student, and with several residents.

During the course of the inspection, the inspector(s) reviewed the health care records of several residents, reviewed two critical incident reports, observed staff to resident interactions, and reviewed the licensee's Abuse and Neglect, January 2011 policy.

It is noted that two critical incident inspections, log # O-002785-11 and log # O-000596-12, were done during this inspection

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy

Pain

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following subsections:

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

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to comply with the LTCHA section (6) (4) (a) in that the staff have not collaborated with each other in the assessment of an identified resident's responsive behaviours, so that their assessments are integrated, consistent and complement each other.

The resident #2 had a period of agitation that was documented in his/her health care record, on a specified day in February 2012. Several interviewed PSWs report that the resident does have frequent periods of agitation, especially during the provision of care. They also reported that the resident has accused staff of not providing care when staff had just finished providing care and of being abusive during the provision of care.

The home's Administrator states that she has been witness to an incident where the resident was loudly accusing staff of abuse during a tub bath when staff were observed not to be abusing the resident. This incident is said to have occurred during the week of April 1, 2012.

The resident's health care record and plan of care does not identify any resident behaviours, assessments, nor their triggers. There are no plan of care interventions related to the resident's reported responsive behaviours even though everyone is aware of the behaviours noted above. [O-000596-12]

The licensee failed to comply with LTCHA section 6 (11) (b) in that the resident's plan of care for pain management has not been revised when the resident's care set out in the plan has not been effective.

The resident #2 is identified as having ongoing pain. The resident states that he/she has constant unrelieved pain that is worse at movement. Several PSW staff state that the resident has ongoing generalized pain that is not relieved and is worse at movement. Medication Administration Records indicates that the resident has been receiving a prn (as needed) narcotic medication two to three times per day since early February 2012, with no documentation related to the effectiveness of this intervention.

The resident's health care record indicates that the resident does not have any other prescribed pain medication. On April 12, 2012, an RN stated that there has been no communication with the physician to review the resident's pain management medication and pain relief interventions. [O-000596-12]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff involved in the different aspects of care collaborate with each other in the assessment of the identified resident and that the plan of care is reviewed and revised because the care set out in the plan of care has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following subsections:

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

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA section 24 (1) (2) in that the Director was not immediately notified of two witnessed incidents of sexual abuse between two residents.

On an identified day in March , 2012, the resident #1 was seen by a PSW to grab the resident # 3 between the legs, while resident#3 was walking in the corridor. Both residents were separated. The RN was immediately notified and prn (as needed) medication given to resident #1. No further monitoring, interventions or assessments related to resident #1 behaviours was noted to be done in his/her health care record. No assessment or monitoring of Resident #3 was found in his/her health care record.

On another day in March, 2012, the resident #1 was found in resident #3's room, and was observed to be inappropriately touching resident #3. Resident #1 was redirected out of room, the RN was immediately notified and a prn psychotropic medication was given to Resident #1. No further monitoring, interventions or assessments related to resident #1 behaviours was noted to be done in his/her health care record. No assessment or monitoring of Resident #3 was found in his/her health care record.

On April 12, 2012, at 10:am, the DOC was not aware of either incident of resident to resident abuse until a few minutes before being interviewed by MOH inspector. The DOC was reviewing Resident #1's health care record in preparation for a psychogeriatric consultation that was occuring later that day, when she noted both incidents of abuse. The DOC states these incidents of abuse were not reported to the home's management and therefore not reported to the Director, as identified in the home's Abuse and Neglect policy, dated January 2011. [O-002785-11]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that alleged and or witnessed incidents of resident to resident abuse are reported to the Director, to be implemented voluntarily.

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 subsections:

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. The licensee failed to comply with LTCHA section 20 (1) in that
the 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 their policy is complied with.

The licensee's Abuse and Neglect policy, dated January 2011, states under Mandatory Reporting: " All cases of suspected or actual abuse must be reported immediately in written form to the DON/Administrator. In the absence of management staff, concerns should be reported immediately to the Charge Nurse, who will notify management staff on call." It also states " The Administrator shall make the report to the Director."

On an identified day in March , 2012, the resident #1 was seen by a PSW to grab the resident # 3 between the legs, while resident #3 was walking in the corridor. Both residents were separated. The RN was immediately notified and prn (as needed) medication given to resident #1. No further monitoring, interventions or assessments related to resident #1 behaviours was noted to be done in his/her health care record. No assessment or monitoring of Resident #3 was found in his/her health care record.

On another day in March, 2012, the resident #1 was found in resident #3's room, and was observed to be inappropriately touching resident #3. Resident #1 was redirected out of room, the RN was immediately notified and a prn psychotropic medication was given to Resident #1. No further monitoring, interventions or assessments related to resident #1 behaviours was noted to be done in his/her health care record. No assessment or monitoring of Resident #3 was found in his/her health care record.

On April 12, 2012, at 10:am, the DOC was not aware of either incident of resident to resident abuse until a few minutes before being interviewed by MOH inspector. The DOC was reviewing Resident #1's health care record in preparation for a psychogeriatric consultation that was occuring later that day, when she noted both incidents of abuse. The DOC states that nursing staff did not report these incidents of abuse to the home's management, as identified in the home's Abuse and Neglect policy. [O-002785-11]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg. 79/10 in that the police were not immediately notified of two witnessed incidents of abuse between two residents.

On an identified day in March , 2012, resident #1 was seen by a PSW to grab resident # 3 between the legs, while resident #3 was walking in the corridor. Both residents were separated. The RN was immediately notified and prn (as needed) medication given to resident #1. No further monitoring, interventions or assessments related to resident #1 behaviours was noted to be done in his/her health care record. No assessment or monitoring of Resident #3 was found in his/her health care record.

On another day in March, 2012, resident #1 was found in resident #3's room, and was observed to be inappropriately touching resident #3. Resident #1 was redirected out of room, the RN was immediately notified and a prn psychotropic medication was given to Resident #1. No further monitoring, interventions or assessments related to resident #1 behaviours was noted to be done in his/her health care record. No assessment or monitoring of Resident #3 was found in his/her health care record.

On April 12, 2012, at 10:am, the DOC was not aware of either incident of resident to resident abuse until a few minutes before being interviewed by MOH inspector. The DOC was reviewing Resident #1's health care record in preparation for a psychogeriatric consultation that was occuring later that day, when she noted both incidents of abuse. The DOC states these incidents of abuse were not reported to the home's management and therefore not reported to the police. [O-002785-11]

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

Specifically failed to comply with the following subsections:

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).

Findings/Faits saillants :

1. The licensee has failed to comply with O.Reg. 79/10 section 53 (4) (b) in that strategies have not been developed and implemented to respond to a resident demonstrating responsive behaviours.

1) On an identified day in March, 2012, resident #1 was seen by a PSW to grab resident # 3 between the legs, while resident #3 was walking in the corridor. Both residents were separated. The RN was notified and a prescribed prn (as needed) medication was given to resident #1. There is no documentation of the medication's effect on Resident #1 behaviours post incident. There is no indication that Resident #3 was assessed post incident.

On another day in March, 2012, resident #1 was found in resident #3's room, and was observed to be inappropriately touching resident #3. Resident #1 was redirected out of room and given a prescribed prn medication. There is no documentation of the medication's effect on Resident #1 behaviours post incident. There is no indication that resident #3 was assessed post incident.

RN and several PSW staff stated on April 12 2012, that after both incidents of inappropriate sexual behaviours towards Resident #3, they continued to redirect Resident #1 away from resident #3. They state that no other new strategies or interventions related to resident #1's responsive behaviours were implemented until the evening of a specified day in March, 2012.

On a third specified day in March, 2012, the evening RN contacted psychogeriatric outreach services and the attending physician in regards to resident #1's inappropriate behaviours towards Resident #3. A new psychotropic medication was prescribed and administered to resident #1.

There is no information in the resident#1's health care record as to why physicians were contacted on evening shift and if the resident had ongoing responsive behaviours during the identified day in March, 2012. The resident's health care record does not identify any other new strategies or interventions related to resident #1 inappropriate responsive behaviours. [O-002785-11]

Resident #2 is reported by several PSWs to have frequent periods of agitation and verbal abuse, especially during the provision of care. They also report that the resident has accused staff of not providing care when staff had just finished providing care and of being abusive during the provision of care. The resident's health care record only notes one period of agitation that was documented in resident #2's health care record, in February 2012, in which a prescribed psychotropic prn medication was given. The effectiveness of the medication was not documented. The psychotropic prn medication is ordered for the resident but the resident's Medication Administration Records from January to April 2012 noted that this medication was only given once on the identified day February, 2012.

Interviewed Nursing staff and the Administrator stated on April 12 and 13 2012, that they have been witness to several incidents where the resident#2 was agitated, resistive to care and loudly accusing staff of abuse.

Resident#2's health care record and plan of care do not identify any of the resident's behaviours, their triggers, behavioural assessments nor behavioural management strategies or interventions. [O-000596-12]

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 strategies are developed and implemented for two identified residents with responsive behaviours, to be implemented voluntarily.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Issued on this 4th day of May, 2012

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