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
Sep 23, 2014	2014_253514_0024	004794-14	Complaint

Licensee/Titulaire de permis

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

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

CARESSANT CARE LISTOWEL NURSING HOME
710 RESERVE AVENUE SOUTH, LISTOWEL, ON, N4W-2L1

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

RUTHANNE LOBB (514)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 17, 18, 19, 2014.

Concurrent inspection #005117-14.

During the course of the inspection, the inspector(s) spoke with the Administrator, Acting Director of Nursing, 3 Personal Support Workers and the Complainant.

During the course of the inspection, the inspector(s) reviewed the clinical records, policies and procedures and other pertinent documents related to this inspection.

The following Inspection Protocols were used during this inspection:
Critical Incident Response
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

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 O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or this Regulation requires the

licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, (a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and (b) is complied with. O. Reg. 79/10, s. 8 (1), as evidenced by:

On September 17, 2014, a review of the home's Abuse and Neglect Policy (revised August 2014) with the Administrator and Acting Director of Nursing (ADON) revealed that the policy and procedure was not followed by the home after a reported incident of alleged abuse of a resident.

The home's Abuse and Neglect Policy states:

Mandatory Reporting:
1. All cases of suspected or actual abuse must be reported immediately in written form to the Director of Nursing/Administrator.

2. After receiving notice of the abuse, the Director of Nursing will immediately notify the Administrator of the initiation of the investigation.

5. The person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident resulted in harm or a risk of harm to the resident, must immediately report that suspicion and the information upon which the suspicion is based, to the Director appointed by the Ministry of Health and Long Term Care.

Staff-to-Resident Abuse:
4. The Director of Nursing, or in his/her absence, the Charge Nurse, will complete a Head to Toe assessment of the resident and document same.
5. The Director of Nursing and/or Administrator, will contact the attending physician and request a complete medical exam of the resident.
7. The Director of Nursing and/or Administrator will notify the resident's Power of Attorney of the alleged abuse immediately.
8. The Director of Nursing/Administrator will immediately notify the police of the alleged, suspected or witnessed incident of abuse or neglect.
9. The Director of Nursing/Administrator will complete a Ministry of Health Critical Incident Summary.

An interview with the Administrator and ADON confirmed that the above areas in the

home's Abuse and Neglect policy and procedures were not followed during the home's investigation of the alleged abuse. [s. 8. (1) (b)]

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 where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, (a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and (b) is complied with. O. Reg. 79/10, s. 8 (1), to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated:
(i) Abuse of a resident by anyone
(ii) Neglect of a resident by the licensee or staff ,or
(iii) Anything else provided for in the regulations, as evidenced by:

On September 17, 2014 the Administrator and ADON confirmed that they did not investigate the alleged incident of physical abuse by a staff member, involving Resident #001 immediately. [s. 23. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated:
(i) Abuse of a resident by anyone
(ii) Neglect of a resident by the licensee or staff ,or
(iii) Anything else provided for in the regulations, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

s. 49. (3) Every licensee of a long-term care home shall ensure that the equipment, supplies, devices and assistive aids referred to in subsection (1) are readily available at the home. O. Reg. 79/10, s. 49 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident has fallen, the resident has been assessed and, if required, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, as evidenced by:

Review of clinical data revealed that Resident #001 had a number of falls within a specified month.

On September 19, 2014, an interview with the ADON confirmed that it is the home's expectation that the Registered Staff complete Head to Toe Assessment documentation on Point Click Care after each fall and complete a Post Fall Investigation Form after each fall.

The ADON confirmed that a Head to Toe Assessment and Post Fall Investigation documentation was not completed or incomplete for Resident #001 after 3 falls in a specified month.[s. 49. (2)]

2. The licensee has failed to ensure that equipment, supplies, devices and assistive aids for the falls prevention and management program were readily available at the home, as evidenced by:

On September 19, 2014 a review of Resident #001's plan of care revealed that the home did utilize a bed alarm and bed side rail up at all times, as per family request, as fall prevention interventions.

The ADON revealed that the home had been using an alarm system for Resident #001, as noted on the Care Plan, the intervention was made inactive as the alarm system had malfunctioned and the home did not have a replacement. [s. 49. (3)]

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 resident has fallen, the resident has been assessed and, if required, a post-fall assessment has been conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: 1. Abuse recognition and prevention. 2. Mental health issues, including caring for persons with dementia. 3. Behaviour management. 4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 5. Palliative care. 6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7), as evidenced by:

On September 17, 2014 an interview with the Administrator and the ADON revealed that the homes mandatory online training was initiated in January/February 2014. The Administrator revealed that August 15, 2014 was the final deadline for the staff to complete the online training and that 3/33 (9%) nursing staff, who provide direct care to residents, had not completed all 12 mandatory courses, including Chapter 6 - Resident's Rights and Abuse training. These 3 staff continue to provide direct care to the residents.

On September 17, 2014 a review of staff training education records for 2014 revealed that 9/43 (21%) of staff had not completed the mandatory education requirement on the Whistle-Blowing Protection and Staff Reporting Policy and Procedure that was scheduled for February 2014.

The Administrator and ADON confirmed that 9 staff had not completed the mandatory training on Whistle-Blowing Protection within the annual time frame for 2014. [s. 76. (7)]

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 all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations: 1. Abuse recognition and prevention. 2. Mental health issues, including caring for persons with dementia. 3. Behaviour management. 4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 5. Palliative care. 6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7), to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's Substitute Decision Maker (SDM) and any other person specified by the resident were notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident, as evidenced by:

On September 17, 2014 the Administrator and the ADON confirmed that Resident #001's SDM and any other person specified by the resident have not been notified of the alleged incident of abuse of the resident or of the results of the home's investigation of the alleged abuse. [s. 97. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's Substitute Decision Maker and any other person specified by the resident are notified within 12 hours upon becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident, to be implemented voluntarily.

WN #6: 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. (2) Subject to subsection (3), the licensee shall make the report within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director. O. Reg. 79/10, s. 104 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director was made within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director, as evidenced by:

An alleged incidence of abuse towards a resident, by a staff member was reported to the ADON on a specified date.

On September 17, 2014, the Administrator and the ADON confirmed that they had not notified the Director of the alleged abuse incident until the after the required deadline. [s. 104. (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 ensure that the report to the Director is made within 10 days of becoming aware of the alleged, suspected or witnessed incident, or at an earlier date if required by the Director, to be implemented voluntarily.

WN #7: 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 :

1. The licensee has failed to ensure that they informed the Director no later than one business day after the occurrence of the incidence of:
4. Subject to subsection (3.1), an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital, as evidenced by:

On September 19, 2014, a review of Resident #001's clinical data revealed that the resident sustained a fall which resulted in an injury. Resident #001 was hospitalized and returned with transfer documentation, indicating a change in health status.

The Administrator and ADON confirmed that the home had not informed the Director no later than one business day after the occurrence of the incident and has not informed the Director of the incident, until requested by Inspector #514 on September 19, 2014. [s. 107. (3)]

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 they inform the Director no later than one business day after the occurrence of the incident of:
4. Subject to subsection (3.1), an incident that causes an injury to a resident that results in a significant change in the resident's health condition and for which the resident is taken to a hospital, to be implemented voluntarily.

Issued on this 28th day of September, 2014

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