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

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, L1K-0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347, rue Preston, 4iém étage
OTTAWA, ON, L1K-0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 15, 2014	2014_327570_0012	O-000916-13	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 MARMORA
58 BURSTHALL STREET, P.O. BOX 429, MARMORA, ON, K0K-2M0

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

SAMI JAROUR (570)

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): July 10, 11, 14, 2014

During the course of the inspection, the inspector(s) spoke with Resident family members, the Director of Care, the Administrator, Registered Practical Nurse (RPN).

During the course of the inspection, the inspector(s) reviewed Resident Health Records, Complaint Information Report, the home's Complaints binder, the home's Complaints Process and Care Plan Policy and Procedure.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Reporting and Complaints

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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care for Resident #1 sets out clear direction to staff in regards to Resident #1`s substitute decision maker (SDM) request of information concerning the care of the resident.

SDM #1 for Resident #1 reported that the home refused to give an update to his sister regarding the care of Resident #1 over the phone on September 24, 2013. According to SDM #1, his sister is also a SDM for Resident #1, and will be referred to as SDM #2 for the purpose of this report.

On July 10, 2014 the Administrator provided inspector a hard copy of e-mail correspondence with SDM #1 and a copy of Power of Attorney (POA) document for Resident #1. The Administrator advised that the RN #104 who took SDM #2's call was a new employee on September 24, 2013 and no longer employed by the home at the time of inspection on July 10, 2014.

Review of the POA for personal care document signed on January 23, 2007 by Resident #1 indicated that SDM #1 and SDM #2 are both listed as power of attorneys for personal care jointly and severally.

Progress notes for Resident #1 indicate that:
- On September 24, 2013 at 18:57 hrs RN #104 documented that SDM #2 was informed she is not listed as POA for personal care and couldn't be given an update about the resident over the phone.

- On September 24, 2013 at 19:09 hrs RPN #102 documented receiving a phone call from SDM #1 who stated that both him and SDM #2 are both Resident #1's POAs for personal care. RPN #102 was able to confirm that SDM #1 and SDM #2 are both listed as POAs for personal care as per admission records and consequently electronic records were updated. RPN #102 notified RN #104 to call SDM #2 for an

update.

On July 11, 2014 during a phone conversation with inspector #570, SDM #2 confirmed that on September 24, 2013 staff refused to update her on her mother's condition and was told she was not the POA for personal care. SDM #2 stated that she did not receive any phone calls from the home that day to give her an update and did not receive any emails from the administrator.

On July 14, 2014 interview with Administrator indicated no direct e-mail correspondence with SDM #2. The Administrator indicated that the RN #104 tried to call SDM #2 but did not get through. There is no documented evidence that a phone call was made to SDM #2 for an update on September 24, 2013. [s. 6. (1) (c)]

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to comply with LTCHA 2007, s. 22(1) in that written complaints concerning the care of a resident or the operation of the home were not immediately forwarded to the Director.

SDM #1 for Resident #1 submitted an e-mail correspondence to the Administrator on September 24, 2013 concerning the care of Resident #1.

On July 10, 2014 during an interview, the Administrator acknowledged receiving the e-mail that was sent on September 24, 2013 by SDM #1. The Administrator replied to SDM #1 via e-mail on September 25, 2013 to address his concerns.

Review of the home's complaints binder of the year 2013 indicated an e-mail correspondence was sent to the Administrator by SDM for Resident #2 on December 4, 2013 concerning the care of Resident #2. The Administrator replied to SDM for Resident #2 via e-mail on December 12, 2013 to address his concerns.

Review of the home's complaints process policy dated March 2012 indicates that written complaints will be reported immediately to the Ministry of Health and Long-Term Care except for a verbal complaint which is resolved within 24 hours.

The Administrator confirmed that the complaints received by e-mail correspondence from SDM #1 for Resident #1 on September 24, 2013 and SDM for Resident #2 on December 4, 2013 were not forwarded to the Director. [s. 22. (1)]

Issued on this 18th day of August, 2014

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