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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130 avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 20, 2016	2016_326569_0021	002290-16	Resident Quality Inspection

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 WOODSTOCK NURSING HOME
81 FYFE AVENUE WOODSTOCK ON N4S 8Y2

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

DONNA TIERNEY (569), ALISON FALKINGHAM (518), MELANIE NORTHEY (563), SHERRI COOK (633)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): August 30, 31, September 1, 6 - 9, 12 - 14 and 16, 2016.

The following intakes were completed within the RQI:
029818-15 - 2636-000013-15 Critical Incident related to alleged staff to resident abuse
030039-15 - 2636-000015-15 Critical Incident related to alleged resident to resident

abuse, behaviours and reporting to the Director
030951-15 - IL-41483-LO Complaint related to resident supplies
030576-15 - IL-41693-TO Complaint / CI 2636-000017-15 related to discharge and behaviours
034229-15 - 2636-000020-15 Critical Incident related to improper care
034364-15 - Follow up Inspection related to reporting suspected abuse, annual training in mandatory reporting, tracking reported incidents and documenting complaints
034365-15 - Follow up Inspection related to preventative maintenance program
005810-16 - IL-43278-LO Complaint related to alleged resident neglect and care issues, sufficient staffing, and emergency plans
005977-16 - IL-43145-LO Complaint related to alleged resident to resident abuse, and consent
007373-16 - 2636-000007-16 Critical Incident related to alleged financial abuse
001486-16 - 2636-000001-16 & 2636-000005-16 Critical Incidents related to resident to resident abuse and behaviours
011331-16 - 2636-000012-16 Critical Incident related to alleged staff to resident abuse
011441-16 - 2636-000011-16 Critical Incident related to falls and reporting to the Director
013049-16 - IL-44365-LO Complaint related to alleged resident to resident/staff abuse and behaviours
016492-16 - 2636-000014-16 Critical Incident related to resident neglect and falls
023842-16 - 2636-000022-16 Critical Incident related to resident to resident abuse

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing, the Assistant Director of Nursing, two Resident Assessment Instrument Coordinators, the Food Services Manager, the full time and part time Nutrition Managers, the Maintenance Supervisor, the Activity Coordinator, the Regional Manager of Patient Care South West Community Care Access Centre (CCAC), the Registered Physiotherapist, two Physiotherapy Assistants, two Food Services workers, one Dietary Aide, two Restorative Care Aides, one Behavioural Supports Ontario Registered Practical Nurse, two Ward Clerks, five Registered Nurses, eight Registered Practical Nurses, fifteen Personal Support Workers, the Residents' Council President, the past Family Council President, four family members and over 40 residents.

The inspector(s) also conducted a tour of the home and made observations of

residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed meal and snack service, medication administration and drug storage areas, resident/staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports and the general maintenance, cleaning and condition of the home.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Admission and Discharge
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
7 WN(s)
2 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 101.	CO #003	2015_416515_0030	563
O.Reg 79/10 s. 90. (1)	CO #004	2015_416515_0030	569

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. 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. The licensee failed to ensure that a person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident or 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 has occurred or may occur immediately reported the suspicion and the information upon which it was based to the Director.

Record review of the "Concerns Complaints" log demonstrated that on a specified date a "Complaint - Form" was completed related to a complaint reported to the home about an identified resident. The form stated that an identified staff member was providing care to the identified resident in a rough and forceful manner. The “Action Taken” by the Director of Nursing (DON) #105 and Administrator #121 documented that they talked to the identified staff member in the past and there was no further concern. It further indicated that the incident happened a while ago and when the complainant reported the incident to DON #105, it was dealt with and there were no further concerns.

Record review of the "Concerns Complaints" log demonstrated that on another specified date, a "Complaint - Form" was completed related to a complaint regarding the same identified resident. The form indicated that the care provided to the resident by the same identified staff member was neglectful in nature. The form stated that the “Action Taken” by DON #105 included reassigning the identified staff member so that they “will not do

direct care with the resident”.

In an interview, DON #105 acknowledged the reported incidents constitute abuse and shared that the incidents of alleged abuse were not reported to the Director.

During an interview with the identified staff member, they shared that they were never interviewed related to the allegations of care provided with force for the identified resident related to the two reported complaints, but rather learned through colleagues that they were removed from the identified resident's care.

The licensee did not immediately report the suspicion of abuse and/or neglect of the identified resident and the information upon which it was based to the Director. [s. 24. (1)]

2. The licensee failed to ensure that a person, who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

During an interview with an identified staff member, it was shared that on two occasions, they had witnessed an identified resident being physically abusive towards another identified resident. The staff member reported the witnessed abuse to Management and received a response that the situation was related to a personal issue and to not get involved.

Record review showed that the home was aware of a history of physical and verbal incidents between the two identified residents and there were many repeated occurrences.

Staff Interviews with several staff members related to abuse demonstrated that they were not familiar or were vague with the roles and responsibilities of mandatory reporting.

Record review of the home's "Abuse & Neglect - Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff" policy last reviewed May 2015, and Policy and Procedure "Critical Incident Reporting" with a review date of September, 2013, verified that the home was to immediately report to the Ministry of Health all suspicions, risks of harm and abuse of a resident by anyone.

In an interview, DON #105 agreed that the behaviour of the one identified resident towards the other identified resident was abusive. DON #105 verified that the home did not complete any investigations related to staff reporting abuse by the one identified resident towards the other identified resident, and the home did not submit any Critical Incidents to the Director.

The licensee failed to ensure that the abuse of a resident by anyone was immediately reported to the Director.

The scope of this issue was determined to be a level 3 which is widespread and the severity a level 2 which is minimal harm or potential for actual harm. There is a history of this legislation being issued in the home as a Compliance Order (CO), Inspection #2015_416575_0030 commencing on October 19, 2015. [s. 24. (1)]

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. 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).

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. The licensee failed to ensure that a Personal Assistive Service Device (PASD) described in subsection (1) that was used to assist a resident with a routine activity of

living was included in the resident's plan of care.

A) An identified resident was observed using a PASD on four separate occasions during the Resident Quality Inspection (RQI).

Interviews with DON #105, PSW #109, PSW #110, RPN #111 and RPN #112 indicated that the identified resident used the PASD for specific requirements.

There was a completed Occupational Therapy assessment, order, and a verbal consent from the Power of Attorney (POA) documented in the progress notes. There was no written signed consent on the identified resident's chart.

Review of the computerized and written resident clinical record revealed no completed specified assessment and no documentation about a PASD for the identified resident.

The home's policy "Personal Assistive Service Devices (PASD)" last revised July 2016 stated "All residents who use PASD's shall have this documented on the Resident Plan of Care". The policy further stated "All residents who require the use of a PASD to perform activity of daily living, shall have this documented in the Plan of Care. Alternatives to the use of PASD's which limit movement shall be considered and tried where applicable. If these alternatives fail, or are deemed ineffective in assisting the resident with ADL's, then a PASD may be used and the least restrictive shall be used. Documentation of this shall appear in the resident's plan of care. The resident must consent to the PASD. If the resident is incapable, then the authorized Substitute Decision Maker(SDM) shall give consent. Consent shall be noted in the plan of care."

DON #105 acknowledged her expectation that the specified assessment be completed prior to the use of a PASD, consent for the use of a PASD be obtained and documented, and the plan of care sets out clear direction to the staff for the use of a PASD.

The licensee failed to ensure that the PASD described in subsection (1) used to assist a resident with a routine activity of living was included in the identified resident's plan of care. (518)

B) An identified resident was observed using a PASD on four separate occasions during the RQI.

Interviews with Restorative Care Aides #122 and #123, Registered Nurse (RN) #124 and Physiotherapist #128 indicated that the identified resident needed the PASD for specific requirements.

Review of the computerized and written resident clinical record revealed that a specified assessment was not completed and the use of the PASD was not included on the resident's care plan or kardex.

The home's policy "Personal Assistive Service Devices (PASD)" last revised July 2016, indicated that all residents who use PASD's shall have this documented on the Resident Plan of Care.

DON #105 acknowledged her expectation that the specified assessment be completed prior to the use of a PASD and documented and the plan of care sets out clear direction to the staff for the use of the PASD.

The licensee failed to ensure that the PASD used by the identified resident to assist with a routine activity of living was included in the identified resident's plan of care. (633) [s. 6. (1)]

2. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A) During an interview with an identified resident, they indicated that they had not received a required treatment and specific service for the designated time they required it. The resident further explained that this treatment and service was an ongoing requirement and that there were repeated episodes of the treatment and service being provided late or not at all. In another interview with the resident later in the same day, the resident verified that the required treatment and specific service was not yet received.

Record review of the current plan of care for the identified resident verified that the identified resident was to receive the required treatment and specific service at a designated time frame on a daily basis.

Observation, interview with Registered Practical Nurse (RPN) #133, and record review indicated that the specified treatment was not present on the floor and given as ordered. Interview with Administrator #121 and DON #105 and an identified staff member verified

that the identified resident's specified treatment was not provided or documented as ordered, as well as receiving the specific service at the required time, and that the expectation was that it should have been.

The licensee failed to ensure that the care set out in the plan of care for the identified resident was provided as specified in the plan.

B) On a specific date, DON #105 submitted a critical incident report to the Ministry of Health and Long-Term Care to inform the Director of the suspected neglect of an identified resident.

Record review of the care plan for the identified resident indicated they had specific care requirements. These specific care requirements were confirmed during three staff interviews.

Interview with DON #105 verified that the identified resident was not provided their specific care requirements as outlined in their clinical record and should have been.

The licensee failed to ensure that the care set out in the plan of care for the identified resident was provided to the resident as specified in the plan.

The scope of this issue was determined to be a level 2 which is a pattern and the severity a level 2 which is minimal harm or potential for actual harm. There is a history of this legislation being issued in the home as a Written Notification (WN), Inspection #2014_229213_0078, commencing on December 8, 2014. [s. 6. (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 a Personal Assistive Service Device described in subsection (1) that is used to assist a resident with a routine activity of living is included in the resident's plan of care, and the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: 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).

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that every alleged, suspected or witnessed incident of the following that the licensee knows of, or that was reported to the licensee, was 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.

Record review of the "Concerns Complaints" log demonstrated that two Complaint - Forms were completed related to complaints reported to the home about an identified resident's care provided by an identified staff member that was forceful in nature on one occasion, and neglectful in nature on another.

During an interview with the identified staff member, they shared that they were never interviewed related to the allegations of care provided with force for the identified resident related to the two reported complaints, but rather learned through colleagues that they were removed from the identified resident's care.

During an interview with DON #105, it was shared that the identified staff member mentioned in the complaint was not interviewed related to the reported incidents of neglect and forced care and an investigation was not commenced immediately following either reported incident.

The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse to a resident by anyone was investigated. [s. 23. (1) (a)]

2. The licensee failed to ensure that every alleged, suspected or witnessed incident of the following that the licensee knows of, or that was reported to the licensee, was 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.

During an interview with an identified staff member, they shared that they had witnessed an identified resident being abusive towards another identified resident. The identified staff member said that Management was informed of the witnessed abuse.

Record review showed that the home was aware of a history of physical and verbal incidents between the two identified residents and there were many repeated occurrences.

Record review of the home's complaints and critical incident binders for a specified time frame showed there was no documentation related to the identified staff member's reports of the related resident to resident abuse.

On September 16, 2016, DON #105 agreed that the behaviors of the one identified resident towards the other identified resident were abusive and no investigations were completed by the home related to any alleged, suspected or witnessed incidents of abuse.

The licensee failed to ensure that every alleged, suspected or witnessed incident of abuse by the identified resident was investigated. [s. 23. (1) (a)]

3. The licensee failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

A) Record review showed that DON #105 submitted a critical incident report (CI) to the Ministry of Health and Long-Term Care (MOHLTC) to inform the Director of the suspected neglect of an identified resident. DON #105 stated in the CI that the “incident is to be investigated”. There was a documented request from Central Intake and Assessment Triage Team (CIATT) on a specified date for an amendment. Further record review showed there was no documented evidence that an amendment was completed by the home.

Interview with DON #105 on September 16, 2016, verified that the amendment and investigation outcome related to alleged neglect of an identified resident was not submitted to the MOHLTC.

The licensee failed to inform the Director in writing the results of the home’s investigation of the suspected neglect of resident #024.

B) A Critical Incident (CI) Report was submitted to the Ministry of Health (MOH) related to abuse of an identified resident. The “analysis and follow-up” stated, “incident is under investigation.” There was a documented request from CIATT for the home to “amend the following CI upon the outcome of the investigation”. There was no documented evidence that an amendment was completed.

During an interview, the DON #105 shared that the results of the abuse investigation were not reported to the Director. (563)

The scope of this issue was determined to be a level 2 which is a pattern and the severity a level 1 which is minimum risk. The home has a compliance history of one or more

unrelated non compliances in the last three years. [s. 23. (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 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, and to ensure that the results of the abuse or neglect investigation are reported to the Director, to be implemented voluntarily.

WN #4: 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 failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

Record review of a complaint submitted to the Ministry of Health and Long Term Care indicated a family member of an identified resident reported the resident was prescribed a treatment despite the Power of Attorney's (POA) wishes for the resident not to receive it.

Record review of the "Resident Information Package" related to "Notification of Families/Substitute Decision Maker/Power of Attorney" stated the home makes every effort to contact Family/Substitute Decision Maker (SDM)/Power of Attorney (POA) at the number(s) on file when there has been a new treatment or medication.

Record review of Physicians Orders in Point Click Care (PCC) documented the specifics of the prescribed treatment. The order was created for a specific date and the treatment was administered the next day. Documentation showed that the treatment was also refused by the resident several times.

Record review of a progress note showed the family voiced to the home that they did not want the identified resident to receive the treatment. Further review demonstrated there was no documented evidence that the resident's POA was notified of the new treatment which had already been provided to the resident.

In an interview with an identified staff member, they shared that the family/POA were called when new treatments were ordered and usually at the time the order was processed, and if the family/POA refused the treatment it would be put on hold and discussed with the physician. The identified staff member shared the POA of the identified resident was notified after the new treatment was administered to the resident for four days.

The licensee failed to ensure that the procedure to notify Families/Substitute Decision Maker/Power of Attorney related to medication changes for an identified resident was complied with.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds has been assessed by a registered dietitian.

During an interview with Resident Assessment Instrument (RAI) Co-ordinator #126 during stage one of the Resident Quality Inspection, it was discovered that an identified resident had a skin integrity issue. This was also documented on the home’s electronic charting system Point Click Care (PCC).

The home’s policy titled “Wound Assessment” with a review date of July 2016, stated "A referral to the dietician shall be made on PCC for all residents with skin and wound issues”.

Record review of PCC showed dietary referrals were titled Caressant Care Nutrition Referral Form 2014. There were referrals and assessments initiated on three different dates and none of these referrals and assessments were related to skin and wound issues. No other nutrition referrals or assessments after a specified date were found to be entered on PCC.

In an interview with RAI Coordinator #126, she acknowledged there was no dietary referral or assessment related to skin and wound issues for the identified resident on PCC. In addition after review of the resident’s hard copy chart, no dietary referral or assessment was found.

The home failed to ensure that the identified resident, who had a skin integrity issue was assessed by a registered dietitian.

The scope of this issue was determined to be a level 1 which is isolated and the severity a level 2 which is minimal harm or potential for actual harm. There is a history of this legislation being issued in the home as a Voluntary Plan of Correction (VPC), Inspection #2014_229213_0078, commencing on December 8, 2014. [s. 50. (2) (b) (iii)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents who required assistance with eating or drinking were not served a meal until someone was available to provide the assistance required.

During a dining service on a specified date, an identified resident who required assistance to eat was observed to have their food and fluids at their place setting and no staff members seated to assist with the resident's meal. A second observation occurring approximately 50 minutes later showed that the food and fluids were still at the identified resident's place setting and no staff members assisting the resident to eat.

On another specified date, the same identified resident was observed at their place setting with the meal and fluids on the table and staff were not seated to assist the resident. Record review of the current care plan for the identified resident documented that the resident required assistance to eat. The kardex informed staff that the identified resident required staff to complete all aspects of eating/feeding.

During a dining service on a specified date, another identified resident was observed over a 13 minute time frame with multiple fluids and the meal at their place setting without a staff member seated to assist them. On another specified date, another Inspector observed the same identified resident in the dining room with the meal served to them and no staff assistance for the resident to eat. Record review of the current care plan for the identified resident documented that the resident was unable to eat independently. The kardex informed staff that the identified resident required staff to complete all aspects of eating of their meals.

During interviews with two staff members, they verified that one staff should be seated to assist residents requiring assistance to eat. During interviews with Nutrition Managers #138 and #139, they verified the expectation that residents would not be served a meal until staff were available to assist as the food would be cold.

The licensee failed to ensure that the identified residents who required assistance with meals were not served a meal until someone was available to provide the assistance required.

The scope of this issue was determined to be a level 1 which is isolated, and the severity a level 1 which is minimum risk. The home has a compliance history of one or more unrelated non compliances in the last three years. [s. 73. (2) (b)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee failed to ensure that a written record was created and maintained for each resident of the home.

During an observation of an identified resident during stage one of the Resident Quality Inspection (RQI), they were found to have a specific device in place.

In a review of the progress notes for the identified resident, DON #105 documented that the resident required the specific device for a specific reason. The use of this device was also documented in the identified resident's current care plan.

The home's policy "Safety Plan – Resident", with a review date of July, 2016, indicated that the resident or the Substitute Decision Maker (SDM) would be required to sign a consent form for the use of the device.

During an interview with DON #105, they said that the resident's SDM had signed a consent form for the device and it would be kept in the resident's hard copy chart. Record review of the identified resident's hard copy chart failed to find a signed consent for the device. DON #105 also reviewed the resident's chart and was unable to find the signed consent.

During another interview with a Registered staff member they shared that they had spoken with the SDM recently and the SDM remembered signing a consent form for the device. The Registered staff member and DON #105 both said that they were unable to locate the identified resident signed consent form.

The home failed to ensure that the required signed consent form for a specific device was maintained in the home for the identified resident.

The scope of this issue was determined to be a level 1 which is isolated, and the severity a level 1 which is minimum risk. The home has a compliance history of one or more unrelated non compliances in the last three years. [s. 231. (a)]

Issued on this 30th day of November, 2016

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

Original report signed by the inspector.

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DONNA TIERNEY (569), ALISON FALKINGHAM (518), MELANIE NORTHEY (563), SHERRI COOK (633)
Inspection No. / No de l'inspection :	2016_326569_0021
Log No. / Registre no:	002290-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 20, 2016
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 WOODSTOCK NURSING HOME 81 FYFE AVENUE, WOODSTOCK, ON, N4S-8Y2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Brenda Van Quaethem

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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:

Order # / Ordre no : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2015_416515_0030, CO #001;

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 :

The licensee must ensure that any allegations or suspicions of abuse of a resident by anyone is reported immediately to the Director.

Grounds / Motifs :

1. The licensee failed to ensure that a person, who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director.

During an interview with an identified staff member, it was shared that on two occasions, they had witnessed an identified resident being physically abusive towards another identified resident. The staff member reported the witnessed abuse to Management and received a response that the situation was related to a personal issue and to not get involved.

Record review showed that the home was aware of a history of physical and verbal incidents between the two identified residents and there were many repeated occurrences.

Staff Interviews with several staff members related to abuse demonstrated that they were not familiar or were vague with the roles and responsibilities of mandatory reporting.

Record review of the home's "Abuse & Neglect - Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff" policy last reviewed May 2015, and Policy and Procedure "Critical Incident Reporting" with a review date of September, 2013, verified that the home was to immediately report to the Ministry of Health all suspicions, risks of harm and abuse of a resident by anyone.

In an interview, DON #105 agreed that the behaviour of the one identified resident towards the other identified resident was abusive. DON #105 verified that the home did not complete any investigations related to staff reporting abuse by the one identified resident towards the other identified resident, and the home did not submit any Critical Incidents to the Director.

The licensee failed to ensure that the abuse of a resident by anyone was immediately reported to the Director.

(633)

2. The licensee failed to ensure that a person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident or 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 has occurred or may occur immediately reported the suspicion and the information upon which it was based to the Director.

Record review of the "Concerns Complaints" log demonstrated that on a specified date a "Complaint - Form" was completed related to a complaint reported to the home about an identified resident. The form stated that an identified staff member was providing care to the identified resident in a rough and forceful manner. The "Action Taken" by the Director of Nursing (DON) #105 and Administrator #121 documented that they talked to the identified staff

member in the past and there was no further concern. It further indicated that the incident happened a while ago and when the complainant reported the incident to DON #105, it was dealt with and there were no further concerns.

Record review of the "Concerns Complaints" log demonstrated that on another specified date, a "Complaint - Form" was completed related to a complaint regarding the same identified resident. The form indicated that the care provided to the resident by the same identified staff member was neglectful in nature. The form stated that the "Action Taken" by DON #105 included reassigning the identified staff member so that they "will not do direct care with the resident".

In an interview, DON #105 acknowledged the reported incidents constitute abuse and shared that the incidents of alleged abuse were not reported to the Director.

During an interview with the identified staff member, they shared that they were never interviewed related to the allegations of care provided with force for the identified resident related to the two reported complaints, but rather learned through colleagues that they were removed from the identified resident's care.

The licensee did not immediately report the suspicion of abuse and/or neglect of the identified resident and the information upon which it was based to the Director. [s. 24. (1)]

The scope of this issue was determined to be a level 3 which is widespread and the severity a level 2 which is minimal harm or potential for actual harm. There is a history of this legislation being issued in the home as a Compliance Order (CO), Inspection #2015_416575_0030 commencing on October 19, 2015. [s. 24. (1)]

(563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2016

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
Long-Term Care Inspections 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
Long-Term Care Inspections 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
Inspection de soins de longue durée
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
Inspection de soins de longue durée
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 20th day of October, 2016

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Donna Tierney

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