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

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

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 31, 2017	2016_255633_0025	034107-16	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 WOODSTOCK NURSING HOME
81 FYFE AVENUE WOODSTOCK ON N4S 8Y2

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

SHERRI COOK (633), MELANIE NORTHEY (563)

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): December 5-8,12-15,19,20, 2016, January 3-6, 9-12,16-18, 19, 2017.

The following intake was completed during this inspection:
033908-16 / 2636-000038-16 Critical Incident related to alleged resident neglect.

A Written Notification (WN #2) and Compliance Order #002 under O. Reg. 79/10, s. 32 identified in this inspection log # 033550-16 will be issued under a Critical Incident Inspection #2016_303563_0042 concurrently inspected upon during this inspection.

A Written Notification (WN #3) and Compliance Order #003 under LTCHA, 2007, S.O. 2007,c.8 s. 23 identified in this inspection log # 033550-16 will be issued under a Critical Inspection #2016_303563_0042 concurrently inspected upon during this inspection.

A Written Notification (WN #4) and Compliance Order #004 under LTCHA, 2007,S.O. 2007, s. 6 (10) identified in this inspection log # 033550-16 will be issued under a Critical Inspection #2016_303563_0042 concurrently inspected upon during this inspection.

During the course of the inspection, the inspector(s) spoke with the acting Administrator, the Director of Nursing, the Corporate Dietitian, the Dietary Services Consultant, the Food and Nutrition Manager, two Resident Assessment Instrument Coordinators, the Registered Practical Nurse/Behavioural Supports Ontario, the Occupational Therapist, the Physiotherapist, two Resident Care Coordinators, four Registered Nurses, one previously employed Registered Nurse, one Registered Practical Nurse, one Nurse's Aide, one Physio Aide, four Personal Support Workers, two Dietary Aides, one Food Services Worker, one Ward Clerk, one Administrative Assistant, one Nursing student, eight residents and one family member.

The inspector(s) made observations of resident care, the meal and snack service and staff and resident interactions. Relevant policies, procedures, program evaluations and the plan of care for the identified resident were also reviewed.

The following Inspection Protocols were used during this inspection:
Dining Observation
Personal Support Services
Reporting and Complaints

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

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. 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 has failed to ensure a resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

The Director of Nursing (DON) submitted a Critical Incident System Report to the Ministry of Health and Long-Term Care (MOHLTC) to inform the Director of the alleged neglect of the resident. The family member of a resident submitted a complaint to the MOHLTC that also reported the alleged neglect of the resident.

Interviews with the resident and family member and record review of the progress notes in PointClickCare (PCC) verified that the resident sustained an injury during a meal. The resident was to be provided specific interventions during meals. Observation of the resident's injury verified that the injury was healing, but still remained.

A Dietary Aide that served the resident agreed that the resident was served a meal without assistance that resulted in an injury.

A Personal Support Worker (PSW), Nurse's Aide, Nursing student, Registered Practical Nurse (RPN), RPN Behavioural Supports Ontario and the DON verified that registered staff refer to the care plan and PSWs rely on the kardex in PCC to obtain resident care information.

Record review of the care plan and kardex in PCC for a resident verified that specific interventions related to eating assistance were not added to the care plan until several days after the incident. The RPN, Resident Assessment Instrument Coordinator (RAI-C), RPN BSO and DON verified the care plan for a resident should have been updated immediately, or sooner than a week or more, and was not.

Interviews with the DON and the acting Administrator verified that the expectation was that residents were not served a meal until staff were available to assist.

The licensee has failed to ensure that a resident who required assistance with eating, was not served until staff was available to provide the assistance required that resulted in a resident injury.

The scope of this area of non-compliance is isolated, the severity was determined to be

actual harm and the home had a history of non-compliance in this subsection of the legislation as it was previously issued as a Written Notification (WN) on October 20, 2016. [s. 73. (2) (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 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, to be implemented voluntarily.

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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that for every resident the plan of care was reviewed and revised when the resident's care needs changed and the care set out in the plan was no longer effective.

A Critical Incident System Report and Complaint was received by the Ministry of Health and Long-Term Care (MOHLTC) to inform the Director of the alleged neglect of a resident.

Record review of the current care plan indicated that a resident required assistive eating devices at meals. Record review of the progress notes in PointClickCare (PCC) indicated that the resident was injured during a meal.

The PSW, Nurse's Aide, Nursing student, RPN, RPN BSO, Director of Nursing (DON) verified that registered staff refer to the care plan and PSWs rely on the kardex in PCC to obtain resident care information.

Record review of the care plan and kardex in PCC for a resident verified that specific interventions related to eating assistance were not added to the care plan until several days after the incident.

The RPN, RAI-C, RPN BSO and Director of Nursing verified that the care plan for the resident should have been updated immediately, or sooner than a week or more, and was not.

The licensee has failed to ensure that the plan of care was revised when the current plan was no longer effective.

The severity was determined to be a level 3 as there was actual harm/risk. The scope of this issue was widespread during the course of this inspection and there is a history of unrelated non-compliance. [s. 6. (10)]

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of neglect of a resident that the licensee knows of, or that was reported to the licensee was investigated immediately and appropriate action was taken in response to every such incident and the licensee failed to report to the Director the results of every investigation.

"Neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The Director of Nursing (DON) submitted a Critical Incident System Report to the Ministry of Health and Long-Term Care (MOHLTC) to inform the Director of the alleged neglect of the resident. The family member of a resident submitted a complaint to the MOHLTC that also reported the alleged neglect of the resident.

Interviews with the resident, family member and record review of the progress notes in PointClickCare (PCC) verified that the resident sustained an injury during a meal. The resident was to be provided specific interventions during meals. Observation of the resident's injury verified that the injury was healing, but still remained.

Record review of the Policy and Procedure titled Response to Complaints last reviewed on February 2014 indicated that "all complaints will be documented, investigated and

formally responded to promptly utilizing the Report of Complaint form". Record review of the Policy and Procedure titled Abuse & Neglect-Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to staff last reviewed August, 2016 indicated that Mandatory Reporting included the DON "immediately notifying the Administrator of the initiation of an investigation" and that the DON and/or Administrator will interview all parties and maintain a written record using the Abuse-Resident Incident Report".

The Dietary Aide that served the meal to the resident and the Food and Nutrition Manager indicated that neither staff had been interviewed by management related to the resident's injury and the Food and Nutrition Manager was not aware that the incident had occurred at all.

The DON and record review of the Complaint Form that was completed by the DON verified that there was no documentation related to the resident's injury. No other additional documentation was completed and an evaluation was not done as there were no investigative steps taken including no interviews with relevant staff, and no review of one of the home's identified policies last reviewed July 2016. There was no report to the Director (MOHLTC) of the results of the investigation by an amendment to the critical incident report made to the MOHLTC or otherwise.

Interview with acting Administrator verified that the expectation would be that an investigation should have been done and a report to the Director (MOHLTC) of the results of the investigation should have been made by the DON and submitted to the Director and was not.

The licensee has failed to ensure that the alleged, suspected or witnessed incident of neglect of a resident that was reported to the licensee was investigated and the results of the investigation reported to the Director (MOHLTC).

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was widespread during the course of this inspection. There was a compliance history of this legislation being issued in the home on August 30, 2016 as a Voluntary Plan of Correction (VPC) in a Resident Quality Inspection #2016_326569_0021. [s. 23.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Dietary and Hydration Program had written goals and objectives, was evaluated and updated at least annually, and a written record that related to each evaluation was completed.

Record review of the Caressant Care Nursing & Retirement Homes Ltd. policy titled Quality Improvement Program- Dietary with last reviewed date of November, 2016 indicated that the Food Nutrition Manager (FNV) or Dietitian were responsible for the quality improvement activities and implementation of the Corporate Quality Improvement plan and an on-going system would be put in place that assessed, monitored and

improved the quality of nutritional care and food service. An annual meal service evaluation would be completed by the Corporate Food Service Consultant or the Corporate Dietitian and corrective action and on-going monitoring of the effectiveness were the responsibility of the FNM or Dietitian of the home. The results of the annual evaluation would be shared at the homes monthly Continuous Quality Improvement (CQI) meetings.

Record review of the policy Caressant Care Nursing and Retirement Homes Ltd. Audits-Departmental with last reviewed date of August 2014, indicated that each department will audit the service provided, action plans will be developed and the results will be analyzed through the Quality Improvement Committee. The policy directed that records would be maintained for two years and that the department Dietary Services Indicator of Meal Service and Snack Cart indicated ten percent of each resident unit would be audited per month.

Record review of the policy titled Caressant Care Nursing and Retirement Homes Ltd-Annual CQI Goals and Objectives with last review date of March, 2015 indicated that each department will set annual goals that were measurable, action plans would be developed and presented to the Quality Improvement Team that reviewed the goals at least quarterly, analyzed outcomes and revised action plans that would be communicated to residents, family and staff.

Record review of the policy titled Caressant Care Nursing and Retirement Homes Ltd-Program Evaluation last reviewed April 2014 indicated that programs were to be evaluated and updated annually and the information was brought to the CQI meeting and reviewed to identify improvement opportunities.

Record review of the CQI meeting minutes dated January 29, March 10, May 30, August 9, and September 8, 2016 indicated the item section "Dietary" of all meetings minutes were blank.

Record review of the completed December 2015 and draft report dated December 2016 titled Quality Improvement/Risk Quarterly Report indicated that the Dietary and Hydration Program was not included in the programs evaluated.

The most recent annual meal service evaluation was completed by Corporate Registered Dietitian CRD in the year 2014 and the acting Administrator agreed that this annual meal service evaluation was the only evaluation of the Dietary and Hydration Program.

Interviews with Dietary Services Consultant (DSC) and the acting Administrator verified that the policies related to the Dietary Program were reviewed by the DSC and the CRD and that they also evaluated the home independently. The Administrator #101 explained that the Dietary and Hydration Program was not reviewed as part of the home's Continuous Quality Improvement Program (CQI) and the current practice and expectation was that the Corporate Registered Dietitian (CRD) completed the dietary evaluation of the home annually and developed an action plan for the home's Nutrition Manager that followed up with identified concerns.

Interview with acting Administrator also indicated that the home's CQI program was "nursing focused" and did not include the Dietary and Hydration Program in the home. Interview with CRD indicated that the Dietary and Hydration Program should be included in the CQI program of the home as this was what other nursing homes did. Interview with CRD and DSC verified that the only annual meal service evaluation completed in the home was completed in the year 2014 and was related to meal service only. CRD agreed that the Dietary and Hydration Program did not have goals and objectives and was not evaluated annually.

The licensee has failed to ensure that the Dietary and Hydration Program had written goals and objectives, was evaluated and updated at least annually, a written record that related to each evaluation was completed.

The severity was determined to be a level 1 as there was minimal harm. The scope of this issue was widespread with a similar compliance history of s.30 (1) 1 being issued in the home on December 8, 2014 as a Voluntary Plan of Correction (VPC) in a Resident Quality Inspection #2014_229213_0078.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home received individualized personal care, including hygiene care and grooming, on a daily basis.

Interview with the Resident Assessment Instrument Coordinator (RAI-C) indicated that the family member of the resident came to the office door with the resident who had a dirty face. The RAI-C explained that she took both the family member and the resident to the office of the Director of Nursing (DON) to immediately report the family's concern and the current condition of the resident. The RAI-C agreed that the resident was not properly groomed and should be.

A family member submitted a complaint to the Ministry of Health and Long-Term Care (MOHLTC) that reported concerns that the resident was not cleaned and had food stained pants and food debris on the legs, clothes and mobility device.

Registered Practical Nurse (RPN), RAI-C, Registered Nurse (RN) and Registered Practical Nurse Behavioural Supports Ontario (RPN BSO) indicated that a resident should not have a dirty face, hands, nails or clothes as this was disrespectful and neglectful. The Director of Nursing (DON) verified that a resident left for a long period of time, a resident that was soiled or not properly bathed or positioned, was not cared for.

Record review of the Caresssant Care Nursing & Retirement Home Ltd., Schedule "A" titled Residents Bill of Rights dated July 2010 verified that every resident had the right to be properly fed, clothed, groomed and cared for.

Record review of the most recent Caressant Care Nursing and Retirement Homes-Dietary Audit tool titled Meal Delivery/Dining Room Audit indicated that "resident's hands and face were not cleaned before leaving the dining room". The acting Administrator indicated that the audit was the only evaluation tool used by the Dietary Program and was completed "possibly in the year 2015". The acting Administrator also verified that the Dietary Program Audit was not completed for the year 2016 at all.

The licensee has failed to ensure that specified residents received individualized personal care, including hygiene care and grooming, on a daily basis.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was widespread during the course of this inspection

for five of five residents with a history of unrelated non-compliance. [s. 32.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Dietary Services and Hydration Program included the development and implementation, in consultation with a Registered Dietitian who was a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services, and identified risks and implemented interventions to mitigate and manage those risks.

The family member submitted a complaint to the Ministry of Health and Long-Term Care (MOHLTC) that reported the alleged neglect of a resident who was also injured during a

meal.

Record review of the home’s documentation related to Dietary Services that included specific records, written resources and relevant policies indicated that identified risks, including the identified risk in where a resident was injured, were not identified and interventions and strategies for staff to mitigate and manage those risks were not included.

Dietary Aide’s, Personal Support Worker’s (PSW's), a Food Services Worker, a Registered Nurse (RN) and the Food and Nutrition Manager (FNM) indicated that staff were not aware of an implemented intervention that responded to the risk of the same injury.

The FNM stated that the home did not implement an intervention to mitigate the risk and safety concern. The Director of Nursing (DON) agreed that there was a risk. The acting Administrator, Dietary Services Consultant (DSC) and Corporate Registered Dietitian (CRD), verified that risk was not identified and interventions to mitigate the risk were not implemented.

Record review of the Caressant Care Nursing & Retirement Homes Ltd. policy titled Quality Improvement Program- Dietary with last reviewed date of November, 2016 indicated that the Food Nutrition Manager (FNM) or Dietitian was responsible for the quality improvement activities and implementation of the Corporate Quality Improvement plan and an on-going system would be put in place that assessed, monitored and improved the quality of nutritional care and food service. An annual meal service evaluation would be completed and corrective action and on-going monitoring of the effectiveness were to be completed by the home.

The most recent annual meal service evaluation was completed in 2014 by CRD and indicated numerous concerns related to the meal service in the home. This evaluation indicated the following concerns:

1) Safe temperature logs for the refrigerator, freezer and food storage were not evaluated.
2) Resident's hands and faces were not cleaned before leaving the dining room.
3) Improper food handling, preparation and storage that did not preserve taste and prevent adulteration, contamination and food-born illnesses.
4) Hectic and unpleasant atmosphere.

5) Meals and plates were not served and cleared course by course was identified as a reoccurring finding.
6) Seconds and alternatives to uneaten meals were not offered.
7) Supervision was not evident and it was not clear who was in charge.

This meal service evaluation also documented the following: "same issues as previously observed continue" and to "make sure staff is supervised in that room" as "questionable practices/attitudes observed in that room." The evaluation also documented "recommend a plan of action be created and implemented to improve the meal service."

The acting Administrator, DSC and CRD were unable to provide a documented action plan completed by the home that included strategies and interventions to mitigate and manage the identified risks related to nutrition care and dietary services in the home as identified on the most recent annual meal service evaluation.

Interview with CRD and DSC verified that strategies and interventions that responded to the risk related the resident’s injury that was sustained during a meal and the risks identified in the 2014 annual meal service evaluation were not implemented in the home.

The licensee has failed to ensure that the Dietary Services and Hydration Program included the development and implementation, in consultation with a Registered Dietitian that was a staff member of the home, of policies and procedures relating to nutrition care and dietary services. The licensee has failed to ensure that the Dietary Services and Hydration Program identified risks related to dietary services, that included the risk that resulted in a resident injury and the risks identified in the most recent annual meal service evaluation; and has failed to implement interventions to mitigate and manage these risks.

The scope of this area of non-compliance is widespread, the severity was determined to be minimal risk/harm and there were no previous related non-compliance in this subsection of the legislation. [s. 68. (2)]

Issued on this 9th day of February, 2017

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

Original report signed by the inspector.