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
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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
Jun 26, 2015	2015_195166_0012	O-001658-15	Resident Quality Inspection

Licensee/Titulaire de permis

SPECIALTY CARE CASE MANOR INC.
400 Applewood Crescent Suite 110 VAUGHAN ON L4K 0C3

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

Case Manor
28 BOYD STREET P.O. BOX 670 BOBCAYGEON ON K0M 1A0

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

CAROLINE TOMPKINS (166), MELANIE SARRAZIN (592), SAMI JAROUR (570)

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): June 8, 9,10,11 and June 12, 2015

Complaint Log O-002227-15 and Critical Incident Log O-002299-15, were inspected concurrently with this Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with Residents, Family members, Personal Support Staff, Executive Director, Director of Care, Assistant Director of Care, Registered Nurses, Registered Practical Nurses, Support Services Supervisor, Dietary Aides, Cook, Residents' Council representative, Family Council representative, Physiotherapist and Activation Aide.

During the course of this inspection, the inspectors toured the resident common areas and resident rooms, observed staff to resident interactions, medication administration, infection control practices, observed dining services, reviewed clinical records, the licensee's investigation documentation and reviewed the licensee's policies related to zero tolerance of abuse and neglect and pleasurable dining.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.

3 WN(s)
2 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 LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. Log O-002299-15

The licensee has failed to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents is complied with.
The licensee's policy# XV-A-10.70, Abuse & Neglect - Zero Tolerance:
Response to suspected or witnessed abuse, duty to report:
All staff members have an obligation to report any incident or suspected incident of resident abuse or neglect by anyone.

An Critical Incident Report, was received by the Director reporting incidents of staff to resident abuse directed towards 5 residents, by one staff.
The incidents of abuse by a staff to residents, included name calling, intimidation, using profanity, rough handling and inappropriate behaviour.

Review of the Critical Incident Report, the licensee's investigation, interview with the Administrator, Director of Care and the Assistant Director of Care indicated that some of incidents of staff to resident abuse were reported to a member of the Registered staff, who did not report the incidents as per the licensee's policy. [s. 20. (1)]

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 receive mandatory education related to the licensee's policy on Abuse, Mandatory Reporting and Whistle Blowing Protection and that the policy related to all the above is complied with, to be implemented voluntarily.

WN #2: 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,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).

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 that no persons simultaneously assists more than two residents who need total assistance with eating or drinking.

During an observation of the noon meal service, staff #103 was observed feeding 3 residents and assisting 1 resident with eating and drinking.

Staff #104 was observed feeding 2 residents and assisting one other resident with eating/drinking simultaneously. [s. 73. (2) (a)]

2. Log O-002227-15

The licensee has failed 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.

During an observation of a lunch meal service, it was observed, that at one table, 4 residents had been served their soup at 12:20 and at 12:40 the soup was still on the table, untouched, there was no staff to assist/encourage the resident as all staff were engaged in serving or assisting other residents.

During an observation of a supper meal service, staff #128 was observed feeding Residents #5, #42 and assisting/ encouraging a third resident. The fourth resident, #47, had been served the meal, but was not able to eat independantly.

While feeding the 2 residents and encouraging the third resident, staff #128 was asked to assist a co worker to bring a resident to the dining room. The two staff left the dining room to assist the other resident, leaving the residents at the table without any feeding/assistance.
Staff #128, was later observed feeding Resident #42 and Resident #47, the meal for resident #47 was reheated as it had been served 20 minutes earlier.

Interview with staff who assisted residents during the noon meal service and interview with staff who assisted the residents at the supper meal service, indicated that due to the cognitive status of the residents and the physical assistance required for the residents at meal times, the staff regularly assist and or encourage more than 2 residents at time during all meal services. [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 persons simultaneously assists more than two residents who need total assistance with eating or drinking and 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 #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents protected from abuse by anyone and free from neglect by the licensee or staff in the home.

“Abuse” — definition
2. (1) For the purposes of the definition of “abuse” in subsection 2 (1) of the Act, “emotional abuse” means,
(a) any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

“verbal abuse” means,
(a) any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident.

physical abuse” means, subject to subsection (2),
(a) the use of physical force by anyone other than a resident that causes physical injury or pain,

A Critical Incident Report (CIR) was received by the Director, reporting incidents of staff to resident abuse.

Review of the CIR, the licensee's investigation, interview with the Administrator, Director of Care and the Assistant Director of Care indicated that there were 5 incidents of staff to resident abuse, all allegedly perpetrated by staff #120.

The incidents of abuse by a staff to resident, included name calling, intimidation, using profanity, rough handling and inappropriate behaviour. A co-worker, staff #121 was present for some of the incidents and actively participated as the second caregiver without protest.

When the licensee became aware of the allegations of staff to resident abuse, an investigation was immediately initiated.

Staff #120 and #121 are no longer employed at the home. [s. 19. (1)]

Issued on this 26th day of June, 2015

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

Original report signed by the inspector.