



Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue

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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Table with 3 columns: Date(s) of inspection, Inspection No, Type of Inspection. Row 1: Oct 24, 25, 26, 29, Nov 1, 2, 5, 2012; 2012_038197_0031; Critical Incident

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

SPECIALTY CARE CASE MANOR
28 BOYD STREET, P.O. BOX 670, BOBCAYGEON, ON, K0M-1A0

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

JESSICA PATTISON (197)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Associate Director of Care, the Director of Resident and Family Services, the Restorative Care Coordinator, a Registered Nurse, Registered Practical Nurses, Personal Support Workers, a family member and residents.

During the course of the inspection, the inspector(s) reviewed a critical incident report, resident health care records, the home's policy related to resident abuse and neglect, the home's internal investigation file, Personal Support Worker report sheets, a disciplinary letter and observed a lunch meal service and staff to resident interactions.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy

Prevention of Abuse, Neglect and Retaliation

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON-RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Legendé</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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.)</p>	<p>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.</p>
<p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following subsections:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

2. Every resident has the right to be protected from abuse.

3. Every resident has the right not to be neglected by the licensee or staff.

4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

5. Every resident has the right to live in a safe and clean environment.

6. Every resident has the right to exercise the rights of a citizen.

7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.

8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.

9. Every resident has the right to have his or her participation in decision-making respected.

10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.

11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 3(1)2 in that a staff member of the home verbally and emotionally abused a resident.

A critical incident report was submitted by the home stating that the following alleged incidents had occurred:

- on a specified date resident #1 was instructed by a staff member that he/she was not to go into the dining room due to being in bed all day and to go for a walk. The same staff member also told resident #1 not to go to bed until after 2300 hours.

- on another occasion resident #1 was incontinent of urine and the same staff member responded to the incident by requiring the resident to write out lines on a piece of paper indicating that he/she was sorry.

During an interview on October 25, 2012 resident #1 verified that writing out lines made him/her feel sad and upset.

During an interview with the Director of Resident and Family Services she stated that resident #1 reported having to write out lines and that this made the resident feel humiliated and embarrassed.

Further interviews with several staff members confirmed that a staff member in the home had verbally and emotionally abused resident #1 on two occasions.

On a specified date action was taken by the home in regards to the reported incidents between the staff member and resident #1.

2. The licensee has failed to comply with O. Reg. 79/10, s. 3(1)14 in that a staff member did not fully respect and promote a resident's right to receive a visitor of his or her own choice.

On October 25, 2012 a staff member stated that resident #2 wanted to visit resident #3 on an unconfirmed date but he/she felt that resident #3 should not be disturbed at that time. The staff member further stated that not allowing the visit upset resident #2.

On October 29, 2012 the health care records for residents #2 and 3 were reviewed and an interview was conducted with resident #3 and a family member. Both the health care records and the interview indicated that residents #2 and 3 enjoy spending time together. There is no indication or instruction to staff that resident #2 should not be allowed to visit resident #3 at any time.

During an interview with the Director of Resident and Family Services on October 29, 2012 she stated that the staff member had stopped resident #2 from visiting resident #3 and that both residents were very upset. She went on to say that resident #3 stated that resident #2 could visit him/her at any time. The home concluded in their investigation of the incident that the staff member had violated both of the resident's rights by not allowing the visit.

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 resident has the right to be protected from abuse and to receive visitors of his or her choice, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10, s. 41 in that desired bedtime and rest routines were not supported for a resident.

The written plan of care last reviewed in October 2012 for resident #1 related to sleep patterns states the following:

- meet individual needs of sleep/rest to function safely and without fatigue
- resident #1 prefers to get up at 0600 hours and prefers to go to bed at 1900 hours
- requires rest periods throughout the day when using assistive walking device as resident deems necessary

On a specified date it was alleged that a staff member told resident #1 that he/she was not to go to bed until after 2300 hours as he/she had been in bed all day.

During an interview with this staff member on October 25, 2012 it was reported that other staff assist resident #1 to bed at 1830 hours and he/she suggested to the resident on a specified evening to stay up due to being in bed all day. The staff member further stated that he/she did not see why the resident could not stay up and that he/she thinks it is sad that resident #1 goes to bed so early.

A disciplinary letter to the staff member states that the home's investigation determined that he/she had advised a resident that he/she was not permitted to go to sleep at their usual time.

WN #3: 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 subsections:

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;
- (b) the goals the care is intended to achieve; and
- (c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

The licensee has failed to comply with LTCHA 2007, s. 6(1)(c) in that the written plan of care related to a resident's mobility/exercise routines and continence care does not set out clear directions to staff and others who provide direct care to the resident.

1. Three direct care staff members were interviewed in regards to caring for resident #1. They all indicated that there has been no specific training or direction for staff related to caring for resident #1.

The plan of care last reviewed October 2012 for resident #1 related to toileting and bladder function states that he/she is continent of bladder and states that the resident is on a toileting routine.

The written plan of care for resident #1 does not indicate all care needs related to continence and does not identify an approach or specific interventions staff should use when these care needs arise.

The Director of Resident and Family Services confirmed on October 29, 2012 that there is no direction to staff in resident #1's written plan of care related to dealing with identified continence care needs.

2. On October 25, 2012 it was reported by a staff member that staff often ask resident #1 to go for a walk to get exercise when early for meals. The staff member also stated he/she has asked the home many times for help in how to best approach the resident.

Another staff member stated on October 29, 2012 that staff tell resident #1 to go for a walk or go do something on occasion. The staff member further stated that there has been no instruction to staff related to caring for resident #1.

Resident #1's plan of care last reviewed October 2012 states:
- Mobility Goal - to increase mobility function/strength/flexibility (ROM)

The written plan of care for Resident #1 does not identify the resident's wish to walk for exercise or if and how staff should encourage the resident to exercise.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written plan of care sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

Issued on this 6th day of November, 2012

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

