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

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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
Jul 7, 2017	2017_660218_0003	010853-16, 014945-16, 024076-16, 026017-16, 030317-16, 030608-16, 031430-16, 032020-16, 033864-16, 034520-16, 035415-16, 006984-17	Critical Incident System

Licensee/Titulaire de permis

CRAIGWIEL GARDENS
221 MAIN STREET R. R. #1 AILSA CRAIG ON N0M 1A0

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

CRAIGHOLME
221 MAIN STREET R. R. #1 AILSA CRAIG ON N0M 1A0

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

APRIL TOLENTINO (218), AMIE GIBBS-WARD (630), MELANIE NORTHEY (563)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 26, 27, 28, 29, 30, 2017.

The following Critical Incident (CI) reports were inspected related to missing medications:
CI #2622-000028-16 Log #026017-17
The following CI reports were inspected related to prevention of neglect:
CI #2622-000049-16 Log #035415-16
The following CI reports were inspected related to falls:
CI #2622-000020-16 Log #014945-16
CI #2622-000009-17 Log #006984-17
The following CI reports were inspected related to prevention of abuse:
CI #2622-000011-16 Log #010853-16
CI #2622-000040-16 Log #031430-16
CI #2622-000044-16 Log #033864-16
CI #2622-000027-16 Log #024076-16
CI #2622-000046-16 Log #034520-16
CI #2622-000041-16 Log #032020-16
CI #2622-000036-16 Log #030317-16
CI #2622-000038-16 Log #030608-16

During the course of the inspection, the inspector(s) spoke with the Executive Director, Interim Director of Care, Registered Nurses, Registered Practical Nurses, Personal Support Workers, and residents.

During the course of the inspection, the inspector(s) also observed residents and the care provided to them, resident and staff interactions, resident rooms, medication administration, reviewed medical records and plans of care for identified residents, postings of required information, minutes of meetings related to the inspection, staff education records, reviewed relevant policies and procedures of the home and internal investigation notes.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Medication
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **3 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. 6. Plan of care

Specifically failed to comply with the following:

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).

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

The Critical Incident (CI) report #2622-000011-16 documented an incident of staff to resident suspected neglect. The CI report stated that the resident asked the Personal Support Worker (PSW) to assist with care three times. However, the resident was left to perform independent care until another staff member offered assistance.

The progress note documented that the resident asked for care assistance and the PSW stated, "you can do it yourself".

The care plan documented that the resident required physical assistance for this care task.

The Executive Director (ED) stated that the PSW thought they were encouraging the resident to continue to provide independent care. The ED acknowledged that care was to be provided as planned and that the PSW was to use wording that provided reassurance to the resident.

The Health Care Aide (HCA) stated there were times that the resident would ask staff for assistance with a certain care task. The HCA verified that this resident was very capable of communicating their needs to the staff.

The licensee did not provide the assistance required by the resident when the resident

requested it. [s. 6. (7)]

2. The licensee has failed to ensure the plan of care was reviewed and revised when the resident's care needs changed related to responsive behaviours.

The CI report #2622-000027-16 documented an incident of alleged resident to resident abuse. The report included long-term actions that were planned to prevent recurrence.

The Registered Nurse (RN) told an Inspector that the resident had responsive behaviours and their mood would change very quickly. The RN said that this resident had a specific trigger that caused a specific behaviour to occur. The RN said they could recall an incident in which this resident was involved with another resident. The RN said that this resident disliked specific residents in the home and the staff had a specific intervention in place to address this.

The clinical record for this resident included several incidences when the resident demonstrated specific responsive behaviours.

The electronic plan of care for this resident identified behavioural triggers involving others. The plan of care did not include identified responsive behaviours or interventions to minimize the risk of specific behaviours. The plan of care was not updated after the incident occurred as mentioned in the CI report.

A PSW said they had a specific intervention in place related to one triggered behaviour. The Inspector reviewed the plan of care for the resident with the PSW and they acknowledged that it had not been revised to reflect the change in responsive behaviours including interventions in place to address other responsive behaviours exhibited by the resident.

The Interim Director of Care (DOC) told the Inspector that they were involved in investigating the incident in this CI report. Interim DOC said that this resident had a history of responsive behaviours. Interim DOC said it was the expectation in the home that the plan of care would be reviewed and revised in order to inform staff of the resident's change in responsive behaviours and the interventions in place to prevent recurrence.

The ED said it was the expectation in the home that whenever there was a change in a resident's care needs that the plan of care would be revised. [s. 6. (10) (b)]

3. The licensee failed to ensure that the plan of care was reviewed and revised when the care set out in the plan was not effective related to falls prevention.

The CI report #2622-000009-17 documented that the resident sustained a previous fall which resulted in a significant injury.

A record review of the plan of care for this resident related to falls included specific falls interventions. The goal noted in the plan of care for this resident was to experience a reduction in falls through the next review date. The resident's history of falls showed that the resident fell six previous times.

A post-fall assessment was completed following the most recent incident and documentation in the post-fall huddle notes stated the measures to prevent another fall. The care plan was revised to include the date of the most recent fall however no changes to the previous plan was implemented to include additional post-fall interventions to reflect the change of the resident's status. An amendment review of the care plan showed that there were no previous interventions implemented or trialed for the previous six falls despite the current interventions being ineffective.

The Inspector reviewed the plan of care for this resident with the Interim DOC. The Interim DOC acknowledged that the falls interventions noted in the plan of care for this resident was not reviewed and revised to reflect a change in status after becoming aware of the resident's injury from the fall. The Interim DOC also acknowledged that the current interventions listed in the plan of care was not reviewed or revised immediately following the previous falls incidences despite being ineffective. The ED stated that the expectation was for all staff to revise the resident care plans immediately with interventions in place to reflect any changes in resident care needs.

The licensee did not review and revise the plan of care when the current interventions set out in the plan of care related to falls were not effective.

The severity of the issue related to plan of care was determined to be a level two with potential for actual harm and the scope was identified as being isolated. This area of non-compliance was issued as a written notification on January 11, 2017 and on April 10, 2017. [s. 6. (10) (c)]

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 care set out in the residents' plan of care are provided as specified in the plan, that the resident is reassessed and the plan of care is reviewed and revised when residents' care needs change and when the care set out in the plan has not been effective, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

The CI report #2622-000011-16 documented that the PSW utilized improper techniques while assisting a resident during a transfer. This resulted in injury to the resident.

The care plan documented that the resident required assistance from staff with transfers and the goal was to transfer safely.

A witness of the incident stated that the PSW did not use safe transferring techniques when assisting the resident.

The Interim DOC acknowledged that the PSW did not follow the plan of care related to proper transferring techniques, the care provided did not constitute a proper transfer technique and that it was not in line with the care planned for the resident.

The severity of this issue related to safe transferring and positioning devices or techniques was determined to be a level two resulting in minimal harm with the potential for actual harm. The scope was identified as being isolated. The home does not have a history of related and multiple unrelated non-compliance in this section of the Long-Term Care Homes Act and Regulations. [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours, where possible.

The CI report #2622-000044-16 documented an incident of a resident to resident physical abuse.

A review of the progress notes documented the resident exhibited responsive behaviours before and after the incident occurred.

The care plan for the identified resident did not have strategies developed to respond to responsive behaviours.

The PSW acknowledged that the resident's care plan did not have interventions in place to direct staff when the resident was demonstrating responsive behaviours.

The ED acknowledged that strategies were not developed and implemented for the resident's responsive behaviours. [s. 53. (4) (b)]

2. The licensee failed to ensure that, for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours, where possible.

The CI report #2622-000011-16 documented an incident of staff to resident physical

abuse while providing care.

The progress notes stated the incident was reported to the registered staff who then reported it to the DOC.

The care plan strategies related to the resident with responsive behaviours focused on the problematic manner on how the resident displayed these behaviours. Specific triggers and strategies were mentioned in the plan of care.

The PSW stated that specific behaviours exhibited during care were normal behaviours for the resident. The PSW acknowledged that the strategies in place were not implemented to respond to the resident's specific behaviours when they exhibited this behaviour during care.

The Interim DOC acknowledged that the strategies in place to respond to the resident's responsive behaviours were not followed by the PSW mentioned in the CI report.

As part of the plan of care for the resident, the strategies in place were not implemented to respond to the responsive behaviours.

The severity of this issue related to responsive behaviours was determined to be a level three as actual harm was inflicted to a resident during the provision of care. The scope was identified to be pattern as the issue affected more than the fewest number of residents in review. The home does not have a history of related and multiple unrelated non-compliance in this section of the Long-Term Care Homes Act and Regulations. [s. 53. (4) (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 for each resident demonstrating responsive behaviours, strategies were developed and implemented to respond to these behaviours, where possible, to be implemented voluntarily.

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 failed to ensure that a written record was kept related to the evaluation of the Falls program that include 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.

The ED and Interim DOC provided clarification to Inspectors related to the home's Falls Prevention program. The ED shared that in Spring of 2017 a unanimous decision was made to permanently remove the "at risk" indicator falling leaf logos for the purpose of concealing personal identifiers.

Interim DOC acknowledged that they were not aware of the update related to the removal of risk identifiers. Staff interviews with a Registered Practical Nurse and a PSW acknowledged that they continued to utilize the falling leaf symbols as a means to identify residents at risk for falls.

Throughout the course of conducting observations, a resident was found to be sitting in a wheelchair with a green leaf indicator attached.

The ED stated that the update related to the removal of risk indicators would have been communicated in the annual Falls Prevention training that took place between September and December 2016. The ED stated that they had no records to demonstrate that a summary of these changes were communicated to the staff. The ED and Interim DOC also stated that they had no documented evidence of a written record to demonstrate that an evaluation of the Falls Prevention program took place in 2016.

The licensee did not have records to indicate that the evaluation of the Falls Prevention program took place in 2016, a written summary of the changes made related to the falls risk identifiers, or a date to specify when these changes were implemented and communicated to staff.

The severity of this issue related to general requirements of the falls program was determined to be a level one with minimum risk and the scope was identified as being isolated. This area of non-compliance was issued as a written notification on August 17, 2015. [s. 30. (1) 4.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed of a missing or unaccounted for controlled substance no later than one business day after the occurrence of the incident.

The CI report #2622-000028-16 documented an incident of a missing/unaccounted controlled substance for a resident. The resident's medication went missing from the package and this resulted in an inaccurate narcotic count. The incident was submitted to the MOHLTC three days after the incident was discovered.

The "Shift Change Narcotic Count" for the resident documented that one tablet to be administered at bedtime was unaccounted for at the shift change narcotic count.

The Medication Incident/Near Miss Report for the resident documented indicated that one tablet was missing and the DOC was notified.

The Interim DOC acknowledged that the incident was submitted late to the MOHLTC.

The licensee failed to ensure that the Director was informed of the missing or unaccounted medication no later than one business day after the occurrence of the incident.

The severity of this issue related to reports regarding CIs was determined to be a level one with minimum risk and the scope was identified as being isolated. This area of non-compliance was issued as a written notification on February 9, 2015. [s. 107. (3) 3.]

Issued on this 21st day of July, 2017

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

Original report signed by the inspector.