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 # / No de registre	Type of Inspection / Genre d'inspection
Jan 11, 2018	2017_533115_0005	026639-17	Resident Quality Inspection

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

TERRI DALY (115), AMIE GIBBS-WARD (630)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 4, 5, 6 and 7, 2017

The following intakes were completed within the Resident Quality Inspection:
Log #017241-17 Critical Incident 2622-000015-17 related to alleged improper/incompetent treatment of a resident.
Log #017639-17 Critical Incident 2622-000017-17 related to alleged staff to resident abuse.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Nutrition Manager, the Activity Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers, a cook, a representative of Residents' Council, family members and 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 medication administration and drug storage areas, resident and staff interactions, infection prevention and control practices, the posting of Ministry information, inspection reports and the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council

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

- **3 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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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 has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

On specific dates a Registered Nurse (RN) and a Personal Support Worker (PSW) both stated that a resident had specific continence interventions in place.

A review of the clinical record for the same resident, found the following:
- The plan of care in PCC and electronic Medication Administration Record (eMAR) did not include the specific interventions related to the residents continence care needs.

On a specific date, a Registered Practical Nurse (RPN) stated that the resident had a specific continence intervention in place that had been ordered by the physician. When asked whether the plan of care included direction for staff regarding the resident's continence intervention, an RPN reviewed the electronic plan of care in Point Click Care (PCC) and identified that this was not included. The RPN reviewed the electronic Medication Administration Record (eMAR) and the physician's order and said that there was an order for a specific continence intervention. The RPN said that at the time of the interview there was nothing included in the resident's eMAR providing direction for staff regarding specific continence care. The RPN said that on a specific date, there was a new order with specific interventions.

A review of the home's policy titled "Continence Management Program" with last reviewed date November 2016, included the procedure that the registered nursing staff would "collaborate with resident/Substitute Decision-Maker (SDM) and family and

interdisciplinary team to conduct a bowel and bladder continence assessment utilizing a clinically appropriate instrument" and that this would be done "after any change in condition that may affect bladder or bowel continence".

The Director of Care (DOC) said it was the expectation that the plan of care in PCC and the eMAR would provide direction for staff regarding continence care for residents with specific continence needs. An inspector and the DOC reviewed the clinical record for a resident and the DOC acknowledged that the staff had not completed a continence assessment for a specific resident after there had been a change in condition that affected the resident's continence. The DOC also acknowledged that this plan of care was not based on the resident's assessment and needs related to continence care. The DOC said it was the expectation that the assessment would have been completed and the plan of care updated to reflect the assessment and the resident's needs for continence care. [s. 6. (2)]

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

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date which indicated there had been allegations of improper/incompetent treatment of a resident.

The plan of care in PointClickCare (PCC) under physician orders stated that the resident required a specific intervention.

An RN showed the inspector a supply of equipment and acknowledged that these items were supplied by the home for the resident's specific intervention.

The DOC explained that on a certain date an RN was responsible to complete the intervention, the equipment was not available and the RN provided an intervention not identified in the plan of care.

During an interview with a Registered Nurse (RN) they stated that the resident had a physician's order for a specific intervention and that the home had been utilizing specific equipment for the intervention.

The physician was notified about the incident by the charge nurse reporting the CIS and stated some concern that the staff member would not have called to hold the

intervention.

During an interview, an RN told the inspector that the intervention utilized in the home by this resident since the initial physician's order had not changed, and that a specific RN had administered this treatment accordingly in the past.

In an interview with the DOC they stated that the equipment utilized for this intervention would be specific and that the staff should have followed the plan of care and called the physician for further directions if there were concerns.

The severity was determined to be a level two as there was a potential for actual harm. The scope of this issue was isolated during the course of this inspection. The home has a history of non-compliance in this subsection of the legislation, it was issued during a complaint inspection on April 10, 2017, and during the Resident Quality Inspection as a Voluntary Plan of Correction on January 11, 2017. [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 care set out in the plan of care is based on an assessment of the resident and the needs and preferences of the resident and that care set out in the plan of care is provided to residents as specified in the plan of care, to be implemented voluntarily.

WN #2: 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. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Section 2(1) of Ontario Regulation 79/10 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well being, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents."

Section 2(1) of Ontario Regulation 79/10 defines verbal abuse as "any form of verbal communication of a belittling or degrading nature which may diminish the resident's sense of well-being, dignity or self worth made by anyone other than a resident."

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date, which indicated there had been allegations of physical abuse and neglect in the home by a staff member towards residents. The CIS report stated that the management of the home had been made aware of the allegations during a staff interview then "immediately hired an outside investigation service" to investigate the allegations of abuse and neglect. The CIS report also stated that the external investigator interviewed several staff members who reported they had observed a former Personal Support Worker (PSW) "being abusive (verbally) and neglectful towards residents."

On a specific date, a PSW said they had been interviewed by an external investigator regarding the care that a former PSW had provided to residents. The PSW said they had observed the former PSW being rough with and verbally abusing a resident as well as other residents. The PSW said they reported this to the external investigator during a specific time period and prior to that had brought forward the allegations to their supervisor the Registered Nurse (RN) who worked on nights. The PSW said that no management in the home had spoken with them regarding these allegations before or after the external investigator had met with them. The PSW said that they did not know about Whistle Blower protection but had received education on the home's policy on the prevention of abuse and neglect and thought they were to report any allegations of abuse or neglect to their supervisor.

A review of the "Investigative Report for Craigweil Gardens" was completed.
- The external investigator had received a phone call on a specific date from Executive Director (ED) requesting an investigation into allegations of resident abuse by a former PSW.

- The "Documentation of Interviews" showed that during interviews four staff members stated they had witnessed the former PSW be abusive and neglectful to residents. Another staff member said that concerns related to the care the former PSW was providing to residents was brought to their attention.

The home's policy titled "Abuse and Neglect" which was last revised November 2014, stated "any staff, volunteer or resident witnessing an alleged/actual abuse or becoming aware of one will immediately report it to the Supervisor or Manager, the Director of Care or the Administrator." The policy also stated that "upon being informed of an alleged act of abuse the Supervisor/Manager will immediately inform the Administrator or Designate."

On a specific date, the ED reported that they had become aware of the concerns with the care a former PSW was providing to residents, when it was reported by another former PSW during an exit interview. The ED said that they immediately called the external investigator and the former PSW was put off work pending the investigation. The ED said that usually the management in the home did their own investigations, but in this situation it was done by the external investigator. The inspector reviewed the documentation from the external investigator with the ED. The ED acknowledged that the documentation showed that the first interview with staff was not conducted until a certain date, which was 22 days after the incident had been reported to the management in the home. The ED said they thought that the former Director of Care (DOC) also completed some of the investigation and documentation but the staff interviews were completed by the external investigator. When asked if any of the staff who had been interviewed as part of the investigation had reported or been interviewed about these allegations of abuse or neglect prior to being interviewed by the external investigator, the ED said that these staff had not reported allegations of abuse or been interviewed by management in the home. The ED said that all of the staff had completed the annual education on prevention of abuse and neglect which included the home's expectation for mandatory reporting. The ED said it was the expectation in the home that staff would immediately report alleged neglect or abuse to their supervisor as per the home's policy. The ED acknowledged that it wasn't until a PSW's exit interview that the alleged abuse of residents by another PSW was brought up and other staff reported concerns related to the same PSW when they were interviewed by the external investigator, that other staff knew about the abuse and did not report it until that time.

The severity was determined to be a level three as there was actual harm. The scope of this issue was isolated during the course of this inspection. The home does not have a

history of non-compliance in this section of the legislation. [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 the written policy to promote zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #3: 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 has failed to ensure that a person who had 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 had occurred, immediately reported the suspicion and the information upon which it was based to the Director.

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date, which indicated there had been allegations of improper/incompetent treatment of a resident.

The report provided information related to a specific intervention not being administered per the resident's plan of care.

The plan of care in PointClickCare (PCC) under physician orders stated that the resident required a specific intervention.

During an interview with a Registered Nurse they stated that the resident had a physician's order for a specific treatment intervention.

On a specified date, a registered staff member reported to management that the Registered Nurse on the previous shift had administered a treatment, however not per the resident's plan of care.

During an interview with the Executive Director and Director of Care (DOC) they stated that they were aware of the incident that had occurred on a specific date, and that the home completed an investigation and the Registered Nurse was terminated.

The ED acknowledged that they were not aware that the CIS report had been submitted on a specific date. The ED stated that they had conducted a full investigation of the alleged incident and found the staff member to be negligent, however the home had not reported the incident to the Director immediately. [s. 24. (1)]

2. The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date, which indicated there had been allegations of staff to resident physical abuse and neglect in the home. The CIS report stated that the management of the home had been made aware of the allegations during a staff interview.

On a specific date, the Executive Director (ED) said that they had been notified on a certain date, by a former Personal Support Worker (PSW) that there were concerns related to the care that a former PSW had been providing to residents. The home said that the home contacted an external investigator, to initiate an investigation into the allegations of staff to resident abuse. The ED said that the external investigator provided updates regarding the investigation and at the end of the investigation provided the home with a report.

On a specific date an inspector and the ED reviewed the "Investigative Report" provided

to the home by the external investigator. The ED acknowledged that this report showed that on a certain date, the external investigator had interviewed the former PSW and during that interview it was reported that the former PSW had allegedly abused and neglected a resident. The ED also acknowledged that this report showed that the external investigator had notified them personally by phone of the allegations. An inspector and the ED also reviewed the CIS report and the ED said they did not know why the allegation was not reported to the MOHLTC until a certain date. The ED said they were unsure as to the reason for the delay as at the time the former Director of Care (DOC) was responsible for notifying the MOHLTC of these incidents. The ED said it was the expectation in the home that the MOHLTC would be immediately notified of all allegations of abuse or neglect in the home.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was a pattern during the course of this inspection. The home has a history of non-compliance in this subsection of the legislation, it was issued during the Resident Quality Inspection (RQI) as a Written Notification (WN) on January 11, 2017 and during a complaint inspection as a Voluntary Plan of Correction on January 4, 2016. [s. 24. (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 a person who has reasonable grounds to suspect that improper or incompetent treatment or care of a resident or that abuse or neglect of a resident by staff that resulted in harm or a risk of harm to the resident has occurred, immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

Issued on this 18th day of January, 2018

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

Original report signed by the inspector.