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 prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 5, 2019	2019_736689_0005	029808-18	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

CASSANDRA ALEKSIC (689), INA REYNOLDS (524)

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): January 31, 2019.

The following intake was completed in this Critical Incident System Inspection:

Related to prevention of abuse and neglect:
Critical Incident Log #029808-18-18 / CI 2622-000012-18.

During the course of the inspection, the inspector(s) spoke with the Director of Care, the Assistant Director of Care, and one resident.

The inspectors also reviewed health care records and plans of care for identified residents, and reviewed policies and procedures of the home.

The following Inspection Protocols were used during this inspection:
Personal Support Services

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

- **1 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	Légende 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. 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 were not neglected by the licensee or

staff.

The definition of neglect, in the Long-Term Care Homes Act (LTCH Act) 2007, O. Reg. 79/10, s. 5.under the heading neglect stated: "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 home submitted a Critical Incident Systems (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date, related to an allegation of resident neglect. The CIS noted that resident #006 was admitted to the home for a short stay visit and upon pick up, the residents' family noted that they were not appropriately dressed and had the same personal undergarments and incontinence product on when they were admitted to the home. The CIS documented that the resident had cognitive impairment, was occasionally incontinent and wore a product, was resistive to care being provided, and had memory deficits.

During an interview on a specific date, the Director of Care (DOC) #103 stated that resident #006 was admitted on a specific date, and discharged on a specific date after a short stay visit at the home. The DOC stated that when the family picked up resident #006, the family informed the home that they were not appropriately dressed and wearing the same incontinence product from when they came to the home. The DOC stated that there was a miscommunication from the staff who thought the resident was more independent, and that the resident would refuse care often.

During the same interview, DOC #103 stated the Personal Support Workers (PSWs) working during the time, did not escalate the issues to the registered staff, but knowing that resident #006 had behaviours, the homes' Behavioural Supports Ontario (BSO) team had created a care plan for when the resident returns for their next respite stay. DOC #103 stated that the responsive behaviours care plan was created after the resident's discharge, however, the initial care plan was created on a specific date during a previous short stay visit. The DOC stated that the care plan to address behaviours related to refusal of care was not included until after the resident's stay. When asked if there was an assessment completed on admission related to identifying responsive behaviours or cognitive capacity for the resident, the DOC could not identify any documented evidence in the residents' clinical records. When asked by the inspector what assessments were to be completed upon admission for a new resident, the DOC stated that an Admission Assessment should be completed in Point Click Care (PCC),

which included assessments related to cognitive capacity, communication, vision, activities of daily living, bowel and bladder, oral, pain management, and a general history of the resident. The DOC stated that they would also expect the bed rail, Morse falls, safe lift and transfer, Braden pressure risk, bowel, bladder and continence, and pain assessments to also be completed. The DOC confirmed that the care plan was not reflective of resident #006's current status, and no updates or revisions to the plan of care were made on upon admission. The DOC also confirmed that no assessments were completed for resident #006 on admission and they would expect that the assessments should have been completed. When asked by the inspector if the incident was founded that staff neglected to provide care to the resident as per their plan of care, the DOC said yes.

Review of resident #006's Census was reviewed in Point Click Care (PCC) and showed the following documentation:
-Specific date of discharge - Discharge Date STOP BILLING
-Specific date of admission- Actual Admit/ReAdmit Date
-Specific date of previous discharge - Discharge Date STOP BILLING
-Specific date of previous admission - Actual Admit/ReAdmit Date

Review of resident #006's clinical records in PCC showed that the resident's care plan related to bed safety, sleep pattern and preferences, eating, toilet, transferring, dressing, mobility, bathing, hygiene, bowel continence, falls prevention, nutrition risk, and oral care had not been updated or revised after their previous admission and discharge date. The care plan noted updates related to responsive behaviours after the most recent discharge date related to refusing personal care. There was no documented evidence that the care plan was created or revised during the resident's most recent short stay visit.

Progress notes were reviewed in PCC and showed the following documentation:
-On a specific date: Nursing progress note stated that the resident was exhibiting behaviours, including refusal of meals. The writer noted that encouragement and assistance was offered and refused.
-On a specific date: Nursing progress note stated that the resident's family member went to the home to pick up the resident and approached the writer to inquire about the resident's care. The family member voiced that the resident was not dressed, remained in a specific type of clothing, and had the same incontinence product and personal undergarments on that they had been wearing on admission. The note documented that the family member also voiced that they had told staff that the resident had an

incontinence product on, but they had wished for staff to use another product while staying at the home. The note stated that the writer voiced that the resident had refused to get dressed prior to a meal that day, and had refused care several times on prior shifts after several approaches by different staff. The note stated that the writer apologized to the family member, and the family member then voiced concerns stating that it was unreasonable to provide a choice to the resident related to their care needs when they had cognitive impairment. The note stated that the home advised the family member that they did have to give resident's a choice and re-approach due to resident's rights, and the family member was understanding of this. The note stated that the writer allowed the family member to voice all their concerns and then the writer relayed this to the registered nurse (RN) in charge at which time the RN discussed the same concerns with the family member with the writer present. The note stated that following the family member leaving, the writer inquired with the PSW on a specific shift, and they had reported that they re-approached the resident and the resident refused personal care. The note stated that when the writer inquired if they had re-approached a second time, they reported that they had not.

Review of resident #006's assessment in PCC showed no documented evidence that admission assessments were completed during the resident's most recent short stay visit.

The home's policy titled Craigwiel Gardens policy and procedures, Volume: admission procedure with a revision date of March 2016, stated the following under the heading "Admission Procedure":
"8. the nurse will complete a physical and functional assessment of the resident and collect admission information from the resident and family member in hopes to learn as much as possible about the resident, his wishes, needs, hopes and desires to enable the Interdisciplinary Team to develop a Resident Centered Care Plan."
"11. the nurse will initiate a resident care plan within 24 hours of admission, based on the information obtained from the admission assessments and interviews, including:
1. Activities of Daily Living, include type and level of assistance required
2. Risk posed to residents: as example falls, skin breakdown, exit seeking with interventions to mitigate risk
3. Risk posed to other: as example potential behavioural triggers and safety measures to mitigate risk
4. Customary routines and comfort requirements
5. Drugs and treatments required
6. Health conditions including allergies and other conditions that staff should be aware

including interventions
7. Skin condition including interventions
8. Diet orders including texture, fluid consistency and food restrictions"

During an interview on January 31, 2019, Inspector #524 obtained the home's policies related to 24-hour admission procedures and procedures for respite care residents. DOC #103 stated that the home was currently transitioning from the Craigwiel Gardens policies to the Extendicare policies, however, based on respite care admissions the policies were not followed.

The licensee has failed to ensure that resident #006 was not neglected by the licensee or staff when the resident's care plan was not updated on admission, admission assessments were not completed as per the home's policy, including behavioural triggers, which resulted in the resident wearing the same incontinence product for the duration of their short stay visit. [s. 19. (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 residents are not neglected by the licensee or staff is complied with, to be implemented voluntarily.

Issued on this 5th day of February, 2019

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

Original report signed by the inspector.