Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux 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 6, 2020	2020_797740_0004	022968-19, 000353-20, 000463-20, 000679-20, 001055-20	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

SAMANTHA PERRY (740), MEAGAN MCGREGOR (721)

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 20, 21, 22, 23, 24, 27 and 28, 2020

The following intakes were completed within the Critical Incident Systems inspection:
Log# 001055-20 / CI# 2622-000020-20 related to allegations of staff to resident abuse;
Log# 000463-20 / CI# 2622-000006-20 related to Responsive Behaviours;
Log# 000353-20 / CI# 2622-000005-20 also related to Responsive Behaviours;
Log# 022968-19 / CI# 2622-000032-19 also related to Responsive Behaviours; and
Log# 000679-20 / CI# 2622-000009-20 also related to Responsive Behaviours.

During the course of the inspection, the inspector(s) spoke with the Chief Executive Officer, the Director of Care, the Assistant Director of Care, Food Services Manager, Registered Nurses, Registered Practical Nurses, Personal Support Workers and residents.

The inspector(s) also made observations and reviewed relevant home policies and residents' clinical records.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

During the course of this inspection, Non-Compliances were issued.
- **4 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	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. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the provision, outcomes and effectiveness of the care set out in the plan of care, related to behaviours was documented.

A) The home submitted three Critical Incident System (CIS) reports to the Ministry of Long- Term Care (MLTC) related to responsive behaviours.

A review of the Extendicare policy titled "Responsive Behaviours", Policy Number: 09-05-01, Date of Origin: September 2010, stated in part that in homes with Point of Care (POC) documentation tablets, tasks focusing on reporting observed behaviour are to be added to a resident file as soon as the behaviour is observed and that all staff were responsible for completing accurate documentation in the resident's health record or on the Responsive Behaviour Record when behaviours were observed.

A review of the Craigwiel Gardens policy titled "Medical Records Documentation", Effective Date: November 2013, Revision Date: March 2016, stated in part that the goal of medical records documentation was "to provide a mechanism for planning and evaluating the care rendered, medically and legally through clear, concise pertinent documentation" and the purpose of the medical record was to "1. Contribute to the on-going medical care of residents. 2. Means of communication between interdisciplinary team members. 3. Review, study and evaluate resident care. 4. Provide data in protecting the legal interests of the resident, the home and staff. 5. Clinical data for research, study and education." The policy further stated that daily care should be documented via the POC system and that if missed documentation on a resident occurred, staff must sign "late entry" and "if it is not written, it did not happen".

A review of resident #001's electronic medical records documented that the resident had responsive behaviours and triggers documented. The staff had specific direction related to interventions and monitoring of the resident and were to report escalating behaviour and patterns.

During an interview with a staff member, they said it was everyone's responsibility for monitoring and that PSW staff would document on POC or verbally tell the registered nursing staff and they would chart this.

During an interview with a staff member, they said that when a resident was identified as having responsive behaviours the Behaviour Supports Ontario (BSO) team would come up with interventions to put into place to manage these behaviours. When asked how resident's behaviours and responses to interventions were monitored and documented,

RN #105 stated registered staff would document on behaviours under the progress notes in PCC and PSW staff would document on behaviours under a task in POC and would also complete paper Dementia Observational System (DOS) charting when there was a change in a resident's behaviour. They said that behaviour documentation was not always completed and they had to rely heavily on information communicated in daily reports or by asking staff to recall information when completing behavioural assessments.

A review of the resident's electronic records showed there was no documentation completed for several day, evening and night shifts related to resident #001's responsive behaviours.

B) The home submitted CIS report #2622-000032-19 to the MLTC related to an incident of physical aggression between resident #002 and resident #005.

A review of resident #002's electronic medical records outlined the resident's triggers and interventions related to their responsive behaviours and reporting requirements. Furthermore, the records showed there was no documentation completed on several day, evening and night shifts related to resident #002's responsive behaviours.

C) During the inspection resident #003 was identified by staff as having a history of responsive behaviours.

A review of resident #003's electronic medical records documented triggers and interventions related to the resident's responsive behaviours and reporting requirements. The records also showed there was no documentation completed on several day, evening and night shifts related to resident #003's responsive behaviours.

During an interview, Assistant Director of Care (ADOC) #102 stated PSW staff would document about behaviours in Point of Care (POC), the ADOC was aware that documentation was not always completed and expected it would be.

The licensee has failed to ensure that the provision, outcomes and effectiveness of the care set out in the plan of care, related to behaviours was documented for resident #001, for resident #002 and for resident #003 on all scheduled occurrences.

2. The licensee has failed to ensure that the provision of the care set out in the plan of care, related to fluid intake was documented.

A) The home submitted three CIS reports to the MLTC for resident #001, related to responsive behaviours.

A review of the Extendicare policy titled "Food and Fluid Intake Monitoring", Policy Number: RC-18-01-01, Last Updated: December 2019, stated in part the following:
- "Each resident's food and fluid intake will be monitored as an ongoing indicator of nutritional and hydration status, and individually assessed for significant intake changes. Corrective actions will be taken and outcomes will be evaluated for identified resident intake concerns."
- The procedure for fluid intake monitoring for PSW staff included documenting resident food and fluid intake after meals and snacks including any special items and nutritional supplements, either on paper or electronically.
- The procedure for fluid intake monitoring for nursing staff included reviewing fluid intake records daily and comparing to individualized fluid target, as assessed by the Registered Dietitian (RD)/designate.

A review of resident #001’s electronic medical records showed concerns regarding adequate fluid intake, as well as interventions and guidance related to required documentation by staff.

During an interview with a staff member, they stated that PSW staff were responsible for monitoring fluid intake and would document this information on POC. The staff member said that if a resident’s fluid intake was lower than their requirements, they would notify the nursing staff and the nurse would then notify the dietitian.

During an interview with a staff member, they stated that PSW staff were responsible for monitoring and documenting resident’s fluid intake on POC. The staff member said that fluid intake documentation was reviewed by registered staff on night shift and that when a resident’s fluid intake was less than 1000mls per day they would assess for signs and symptoms of dehydration and document a fluid alert note under the resident’s progress notes in PCC.

Further review of resident #001's electronic records showed there was no documentation completed on several day, evening and night shifts related to resident #001's fluid intake.

During an interview, Registered Dietician (RD) #106 stated they would assess residents' fluid intake quarterly and when they received referrals for low fluid intake. RD #106 said

staff were expected to complete a dietitian referral when a resident's fluid intake was less than 1000mls per day, unless the resident was listed on the home's chronic poor fluid intake list. When asked who was responsible for monitoring and documenting resident's fluid intake, RD #106 stated the PSWs were responsible for monitoring and documenting this information in POC. RD #106 said that when assessing a resident's fluid intake, they reviewed the look back report for tasks related to fluid intake under the reports section in PCC to find documented information on a resident's fluid intake. When asked if documentation on resident fluid intake was being completed in POC, RD #106 stated about half of the time documentation was not completed and they would have to rely on the days with the most complete documentation to assess a resident's fluid intake status and would note there was poor documentation in the assessment.

B) During the inspection resident #002 was identified on the home's chronic poor fluid intake list and staff were directed to encourage fluid intake at every opportunity.

A review of resident #002's electronic medical records indicated the resident had poor fluid intake, the records documented interventions and reporting requirements related to the resident's fluid intake and they showed there was no documentation completed on several day, evening and night shifts related to the resident's fluid intake.

C) During the inspection resident #004 was identified on the home's chronic poor fluid intake list.

A review of resident #004's electronic records showed interventions and required documentation related to fluid intake. The records also showed that there was no documentation completed on several day, evening and night shifts related to fluid intake.

During an interview, ADOC #102 stated PSW staff would document fluid intake on POC and the RN on nights would review this information. If intake was below a resident's benchmark they would document fluid alerts for staff to follow-up the next day. ADOC #102 said they were aware documentation on POC was not being completed and expects it would be.

The licensee has failed to ensure that the provision of the care set out in the plan of care, related to fluid intake was documented for resident #001, for resident #002 and for resident #004 on all scheduled occurrences. [s. 6. (9)]

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 with the home's documenting process of the provision, outcomes and effectiveness of the care set out in the plan of care, related to resident behaviours, this is, to be implemented voluntarily.

WN #2: 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 protected from abuse by the licensee and staff.

Critical Incident System (CIS) report #2622-000009-20 was submitted by the home to the Ministry of Long-Term Care (MLTC) regarding an incident of alleged staff to resident abuse.

Review of Craigwiel Gardens policy titled “Abuse and Neglect Prevention Program “, Effective Date: November 2013, Revised Date: July 2016, documented the following:
- Under the heading “Policy: Under no circumstances will abuse or neglect of residents, families, visitors, volunteers or staff be tolerated. All staff and volunteers of the home are expected to fulfill their moral and legal obligation to report any incident or suspected incident of resident abuse.”
- Under the heading “Definition of Abuse: Abuse means any action or inaction, misuse of power and/or betrayal of trust or respect by a person against a resident, family member, volunteer, visitor or staff member. Abuse is a violation of the rights, dignity, and worth of an individual or a group of individuals.”

Review of the home’s investigation notes documented several interviews conducted by the home as part of their investigation and follow up with all relevant staff members involved.

Review of resident #006’s electronic medical records recorded several responsive behaviours, triggers for those behaviours, the resident's cognitive capacity and interventions for staff to assist the resident with their responsive behaviours. The records also documented the staffs account of the incident.

During an interview with a staff member, they said they were familiar with resident #006, that they did not receive consent before providing care and should have.

During an interview, ADOC #102 said they were familiar with resident #006 and the incident and when asked about the staff member's actions, ADOC #102 said that the staff member did not obtain consent or explain their actions to resident #006 and should have.

The licensee failed to ensure that resident #006 was protected from abuse by the licensee and staff in the home. [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 all residents are protected from abuse by the licensee and staff, this is, 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 comply with s. 24 (1) 2, in that a person who had reasonable grounds to suspect abuse of a resident, failed to report the alleged abuse immediately to the Director in accordance with s. 24 (1) 2 of the LTCHA.

Pursuant to LTCHA 2007, s. 152(2) the licensee is vicariously liable for staff members failing to comply with subsection 21 (1).

A) The home submitted Critical Incident System (CIS) report #2622-000008-20 to the Ministry of Long-Term Care (MLTC), related to an incident of physical aggression between resident #001 and resident #004.

A review of the Craigwiel Gardens policy titled "Mandatory Reporting", Effective Date: November 2013, Revision Date: March 2016, stated in part the following:
- Any person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the home or staff that resulted in harm or risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to their Supervisor, the Director of Care or the Administrator.
- All staff members, associates, partners and volunteers who witness or suspect the abuse of a resident, or receive complaints of abuse, are required to report the matter immediately to their supervisor, the Charge Nurse, Director of Care or the Administrator.
- Any staff member is guilty of an offence under the Long Term Care Homes Act if they fail to make a report required by the legislation.

During the course of this inspection a review of resident #004’s electronic records showed documentation of another incident related to physical aggression involving the aforementioned residents.

A review of the MLTC Critical Incident reporting system showed that no CIS reports were submitted related to the documented incident where resident #001 was physically aggressive with resident #004.

During an interview with a staff member, they stated they would consider abuse to be anything that would harm a resident. When asked what their understanding was of their role if they saw or suspected any abuse in the home, the staff member said they would report it immediately to their supervisor or charge nurse.

During an interview with a staff member, they said they would report abuse immediately to the charge nurse, Assistant Director of Care (ADOC), Director of Care (DOC) and MLTC.

During an interview, ADOC #102 stated they would report abuse to the MLTC, that themselves and the DOC would submit CIS reports to the MLTC and that if they were not in the home at the time then registered staff would call the Service Ontario After-Hours Line. ADOC #102 stated that they would consider abuse to be anything that happened to a resident that the resident didn’t want to happen. When asked if they expected that the incident of physical aggression involving resident #001 and resident #004 should have been reported to the MLTC, ADOC #102 said they would.

B) Critical Incident System (CIS) report #2622-000009-20 was submitted by the home to the Ministry of Long-Term Care (MLTC), regarding an incident of alleged staff to resident abuse.

During an interview with a staff member, they said the incident was reported to them right away. The staff member did not report the incident immediately to management as they did not suspect abuse. They said they understood the legislation, the expectation of the home and should have reported the incident right away.

During an interview, ADOC #102 said they were familiar with resident #006 and the incident. When asked why the incident was not reported immediately, ADOC #102 said they were not aware of the incident until the following day. When ADOC #102 questioned the staff member regarding the incident, they said they didn't think it was reportable. ADOC #102 said it would be their expectation that staff report all suspected and alleged incidents of any kind of abuse immediately to management or directly to the Ministry of Long Term Care (MLTC).

The licensee failed to ensure that when a person who had reasonable grounds to suspect that abuse of resident #004 and resident #006, that resulted in harm or risk of harm had occurred, that the information upon which it was based was immediately reported to the Director. [s. 24. (1)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's substitute decision-maker and any other person specified by the resident were notified immediately upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident that caused distress to the resident that could potentially be detrimental to the resident's health or well-being.

A) Critical Incident System (CIS) report #2622-000009-20 was submitted by the home to the Ministry of Long-Term Care (MLTC) regarding an incident of alleged staff to resident abuse.

Specifically, the licensee did not immediately notify resident #006's Power of Attorney (POA) and or Substitute Decision Maker (SDM) upon becoming aware of the alleged, suspected or witnessed incident of abuse.

There were no progress notes documenting that resident #006's SDM was immediately notified of the suspected and or alleged incident of abuse.

During an interview, ADOC #102 said they were familiar with resident #006, the incident and when asked why they did not immediately inform resident #006's SDM regarding the incident, ADOC #102 said they did not know.

The licensee failed to ensure that resident #006's substitute decision-maker and any other person specified by the resident were notified immediately upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident that caused distress to the resident and could potentially be detrimental to the resident's health or well-being. [s. 97. (1) (a)]

Issued on this 10th day of February, 2020

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

Original report signed by the inspector.