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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jan 7, 2016	2015_360111_0028	033594-15	Resident Quality Inspection

Licensee/Titulaire de permis

CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE WOODSTOCK ON N4S 3V9

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

CARESSANT CARE LINDSAY NURSING HOME
240 MARY STREET WEST LINDSAY ON K9V 5K5

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

LYNDA BROWN (111), BAIYE OROCK (624), CHANTAL LAFRENIERE (194), JULIET MANDERSON-GRAY (607), MARIA FRANCIS-ALLEN (552)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 14 -18, 21-23, 2015

The following logs were completed concurrently during this inspection: 4 complaints (004609-14, 005900-14, 007558-14 & 027259-15), 7 critical incidents (005918-14, 006422-14, 001458-15, 012651-15, 024781-15, 034769-15 & 034765-15).

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the RAI Coordinator, Activity Director, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Residents, Families, Resident Council President, Environmental Service Manager, Housekeeper(HSK)and the Resident Care Coordinator (RCC). A tour of the home was conducted, observation of meal services, medication administration, review of health care records of current and deceased residents, review of the home's complaints and investigations, staff records, and review of the following home's policies: zero tolerance of abuse and neglect, safety plan, windows, complaints, windows audits, reporting of repairs, and maintenance requisition procedures.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

14 WN(s)
10 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan related to toileting needs.

During an interview with Resident #001 in stage 1 of the RQI, the resident brought forward concerns that PSW #148 would not provide assistance with toileting/transferring when requested by the resident.

Review of Resident #001 plan of care indicated the resident requires extensive assistance by staff with transferring and toileting(#552).

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 plan of care provides clear directions is provided to staff and others who provide direct care to residents related to transferring and continence care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

Related to log # 004609-14:

Under O.Reg. 79/10, s. 48(1) Every licensee of a long term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incident of falls and the risk of injury.

Review of the home's "Safety Plan-Resident" (revised May 2015) indicated on page 8 of 9:
Part C Post fall Management:
-notify the attending physician and ensure immediate treatment after the fall as indicated.

Review of the progress notes for Resident #065 indicated on a specified date and time, the resident was found on the floor with a PSW present. The PSW reported assisting [Resident #065] with dressing and repositioning when the resident fell to the floor. The resident sustained an injury to a specified area as a result.

There was no indication the physician was contacted regarding the fall or the injury as per the home's policy despite the resident sustaining an injury to a specified area.

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 the home's policy on Falls Prevention and Management was complied with, to be implemented voluntarily.

WN #3: 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 home's written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

Related to log # 012651-15 & 02759-15:

Review of the home's policy "Abuse & Neglect-staff to resident, family to resident, resident to resident, resident, resident and/or family to staff" (revised August 2014) indicated:
-under definitions of physical abuse: includes deliberate exposure to noxious conditions.
-on page 5/10 under mandatory reporting: all cases of suspected or actual abuse must be reported immediately in written form to the DOC/Administrator. In the absence of management staff, concerns should be reported immediately to the Charge Nurse. The reporting person should have written documentation including the following: the date and time that the incident occurred.
-on page 7/10 staff to resident abuse: the supervisor of the alleged abuser will ensure that the immediate needs of the resident are attended to. The charge nurse will complete a head to toe assessment of the resident and document same. The DOC, and/or Administrator will notify the resident's POA and contact the attending physician and

request a complete medical exam of the resident.

A critical incident report (CIR) was received on a specified date and time for an improper/incompetent treatment of a resident. The CIR indicated that on the same day, Resident #047 reported physical abuse by a staff member that was sustained during personal care.

Review of the health record of Resident #047, interview of staff (S#104,S#116 and the Administrator) and review of the home's investigation indicated: on a specified date and time the resident reported to S#104 physical abuse by S#115. S#104 indicated the incident was immediately reported to S#116. S#116 indicated the incident was not reported until approximately four hours later. There was no documentation of the incident on the resident's progress notes to indicate the incident had occurred, the resident was assessed, or to indicate the SDM or physician was notified. S#104 also indicated awareness of previous physical abuse towards Resident #047 by S#115.

Therefore, the policy was not followed as a staff member engaged in physical abuse towards a resident, the staff member who suspected the abuse did not immediately report the incident to the charge nurse, the charge nurse did not assess the resident, document the incident and the assessment, and there was not documented evidence the resident's SDM or the physician was notified.

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 the home's policy to promote zero tolerance of abuse and or neglect is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that appropriate actions are taken in response to every such incident.

Related to log # 012651-15 & 02759-15:

A critical incident report (CIR)was received on a specified date and time for an improper/incompetent treatment of a resident.

Review of the home's investigation indicated that S#115 received disciplinary action as a result of the home's investigation, but there was no actions taken regarding staff failing to immediately report an allegation of staff to resident abuse and regarding a staff member failing to document the incident and the assessment of the resident.

2. Related to Intake #001456-15:

A critical incident report (CIR) was received on a specified date for a written complaint regarding an allegation of verbal/emotional abuse by S#128 towards residents and improper/incompetent treatment of 15 residents.

Review of the home's investigation, interview of residents and Administrator, and review of health care records for 15 Residents (#024,#048, #049, #050, #051 #052, #053, #054, #055, #056, #057, #061, #062, #063 and #064)indicated the following:
-Resident #052 and #024 were interviewed, but the remainder residents were either cognitively impaired or deceased and could not be interviewed.
-interview of the Administrator indicated S#126 reported an allegation of staff to resident verbal/emotional abuse and incompetent care towards several residents by S#128. The Administrator indicated the S#126 reported the allegation two days after the CIR was submitted. The Administrator also indicated S#128 had two prior incidents of staff to resident abuse.
-review of the written allegation by S#126 indicated the letter was not dated but the attached 'complaint form' that was completed by the Administrator was two days after the CIR was submitted. The investigation concluded that S#128 provided incompetent care towards 15 residents and was verbally and emotionally abuse to Residents.
-interview with the Administrator indicated the actions taken by the home included S#128 receiving disciplinary action on three separate dates for verbal/emotional abuse and incompetent care. The Administrator also indicated S#128 role was changed as a result but was unable to indicate when S#128 role had changed (#607).

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 appropriate actions are taken in response to any incident of alleged, suspected or witnessed incidents of abuse and/or neglect of residents by staff, to be implemented voluntarily.

WN #5: 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 when a person who has reasonable grounds to suspect that any of the following has occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

Related to Intake #001456-15:

An allegation of a staff to resident verbal/emotional abuse was received by the home by S#126 on a specified date. The Administrator confirmed that the expectations around the reporting of abuse is immediate.

Review of the allegation by S#126 to the Administrator was not dated (but a "complaint form" attached was dated). The allegation indicated "reported to" S#126, "on several occasions" that residents expressing fear of S#128, verbal/emotional abuse, and incompetent care by S#128.

Interview with S#126 and S#127 stated that "they were aware [S#128] was emotionally and verbally abusive to resident's many days prior to reporting it"(#607).

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 the Director is immediately notified of any suspected, witnessed or alleged incidents of staff to resident abuse or misappropriation of resident funds., to be implemented voluntarily.

WN #6: 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 has failed to ensure that safe transferring and positioning devices or techniques were used when assisting residents.

Related to log #004609-14:

Review of the health record for (deceased) Resident #065 indicated on a specified date and time, the nurse was called to the resident's room and found the resident and a staff member sitting on the floor. The staff member reported repositioning the resident when the resident slipped to the floor and resulted in injury to a specified area. The resident was not wearing appropriate footwear.

Review of the plan of care for Resident #065 (prior to the fall) indicated the resident required two staff assistance with dressing/repositioning and was a high risk for falls.

Therefore, the staff failed to use safe transferring and positioning techniques when assisting the resident with dressing/repositioning resulting in the resident falling and sustaining an injury to a specified area.

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, to be implemented voluntarily.

WN #7: 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 the behavioural triggers for the resident were identified were possible, to respond to the resident demonstrating responsive behaviours.

Related to log #024781-15:

A Critical Incident Report (CIR) was received by the home on a specified date indicating that the day before, staff reported physical abuse by Resident #044 towards Resident #045.

Review of the clinical health records for Resident #044 indicated the resident was admitted to the home with diagnosis including cognitive impairment.

Review of the progress notes for Resident #044 for a four month period indicated there were two incidents. The first incident where the resident demonstrated physical responsive behaviours(identified in the CIR) and the second incident where the resident demonstrated sexually inappropriate responsive behaviours. The recipient of the sexually inappropriate responsive behaviour was not identified.

Interview with S#101 and S#102, both indicated unawareness that Resident #044 demonstrated physical or sexually inappropriate responsive behaviors. Interview of S#116 indicated awareness of Resident #044 demonstrating physical responsive behaviours but was unaware of the resident demonstrating inappropriate sexual responsive behaivours.

Review of the current care plan for Resident #044 indicated the resident demonstrated sexually inappropriate responsive behaviours towards other residents. The interventions included:
avoid type of conversation that could encourage or initiate inappropriate behavior,constant supervision in recreation programs, determine cause and previous history and document it; determine what triggered/lead up to the behavior; and document a summary of each episode. The care plan identified the resident's potential for physical responsive behaviours between another resident. Interventions included: approach slowly and from the front; be sure to have the resident's attention before speaking; document summary of each episode-noting causes and successful interventions, including frequency and duration; staff to monitor interactions with other residents.

The care plan failed to identified the triggers related to the inappropriate sexual responsive behaviours despite the trigger was specific to certain residents. The care plan also failed to identified the triggers for the physical responsive behaviours as they did not identify who the behaviours were displayed towards despite the trigger was a specific resident(#552).

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 the behavioural triggers are identified for the resident demonstrating sexually inappropriate and physically/verbally aggressive responsive behaviours, where possible, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to

one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was investigated, resolved where possible, and response provided within 10 business

days of receipt of the complaint.

Inspector #607 interviewed Resident #006 and the resident indicated a specified amount of money went missing after being admitted to the home. The resident indicated a verbal complaint was reported the nurse regarding the missing money. The resident also indicated the nurse asked if the resident "would like police" contacted but the resident refused.

Review of the progress notes for Resident #006 indicated approximately a month after admission, the resident reported to the charge nurse that a specified amount of money had gone missing since admission. The resident was "encouraged to file police report but refused".

Interview of the Administrator indicated no "report of complaint form" was completed for the this complaint of missing money so there was no investigation completed.

2. The licensee has failed to ensure that for every written or verbal complaint made to the licensee or a staff member concerning the care of a resident, or operation of the home is dealt with as follows:
1.the complaint shall be investigated and resolved where possible, and a response provided to the complainant within 10 business days of receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

Related to log # 007558-14:

A written complaint letter by the SDM of Resident #060 was received by the home on a specified date related to resident care and injury of unknown cause.

Interview of the Administrator indicated the corporate office received the written complaint on a specified date and was not provided the written compliant until the following day. The Administrator indicated a response was not provided to the complainant upon completion of the investigation indicating what the licensee had done to resolve the complaint or that the licensee believed the complaint to be unfounded or founded, and the reasons for the belief.

Review of the home's investigation into the written complaint indicated the complaint was received by the Administrator (the same day it was received by the corporate office) and

some of the care concerns were founded with actions taken. The Administrator indicated "need to book an early meeting" with the SDM "to inform we have addressed these issues" but there was no documented evidence that this occurred(#194).

3. The licensee has failed to ensure that for those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.

Related to Intake #001456-15:

A Critical Incident Report (CIR) was submitted to the Director on specified date for an allegation of staff to resident verbal/emotional abuse and incompetent care by S#128 towards 15 residents. The CIR indicated the incident was said to have occurred two days before.

Interview of the Administrator and review of the home's investigation indicated a written complaint was received regarding the allegations and there was no documented evidence a response to the complainant was provided within 10 business days. A review of the response letter to the complainant indicated a response was not provided until approximately 15 days later and only acknowledged receipt of the complaint letter (not the outcome of the home's investigation)(#607).

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 written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is investigated and resolved where possible, a response provided within 10 days of receipt of the complaint, and a documented record is kept in the home indicating the nature of the each verbal or written complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, the final resolution, if any, and every date on which any response was provided to the complainant and a description of the response., to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following description of the individuals involved in the incident: (ii) names of any staff members or other persons who were present at or discovered the incident.

Related to log # 012651-15 & 02759-15:

A critical incident report (CIR) was received on a specified date for a improper/incompetent treatment of a resident that resulted in harm or risk of harm to the resident. The CIR indicated that on the same day Resident #047 reported a staff member was physically abusive. The CIR did not indicate the name of the staff member involved in the incident.

2. The licensee has failed to ensure that the report to the Director included the following description of the individuals involved in the incident:
(i) names of all residents involved in the incident,
(ii) names of any staff members or other persons who were present at or discovered the incident, and
(iii) names of staff members who responded or are responding to the incident

Related to Intake #001456-15:

Review of the home's investigation (related to CIR) revealed that several staff and 15 residents (Resident #024,#048,#049,#050,#051,#052,#053,#054,#055 #056,#057,#061,#062,#063 and #064) were involved in allegations of staff to resident verbal abuse and incompetent care by S#128 brought forward. The investigation also revealed that some of the residents mentioned they were "afraid" of S#128. A review of CIR did not identify the names of 4 Resident (#061, #062, #063, #064) and 4 staff (S#144, #145, #146, and #147) that were a part of the investigation. An interview with the administrator revealed that the home had not amended the CIR with this information (#607).

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 report to the Director includes a description of all the individuals involved in the incident, including staff members and residents, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Related to Intake #001456-15:

A review of the home's investigations notes, interview of staff and review of CIR indicated Resident 048, 049, #050, #051 # 052, #053, #054, #055 #056 and #057, # 024 #061, #062 # 063 and #064 for a one month period revealed that the residents did not receive their topical and inhalation medication as prescribed by S#128. A review of medication administration records and investigation notes for 5 residents (#024, #061, #062, #063 and #064) revealed for a one week period in the same month, these residents were to receive topical medications and were signed off as being given by S#128, but were not given as the containers had remained sealed. Interview with Resident #052 revealed that S#128 often refuses to give his/her routinely administered specific medications as prescribed and would only receive them when he/she asked for them. Interview with the administrator confirmed that the staff did not administer the medications as prescribed, for the specified residents (#607).

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 drugs are administered to residents in accordance with the directions for use specified by the presciber, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres(cm).

The following observations were noted from December 14 to 18 2015: one window located on the ground floor (A-Wing) north resident lounge area, two windows in the large dining room on (A-Wing) and one window in the ground floor family room opened greater than 15 cm. There were residents noted in the dining area and north lounge area during the observations.

Interview with the Environment Service Manager confirmed that the windows were open greater than 15cm and were repaired immediately(#607).

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director is immediately notified of any written complaint received concerning the care of a resident.

Related to log # 007558-14:

On a specified date, the Administrator became aware of a written complaint by the SDM of Resident #060 related to provision of care concerns and the resident sustaining an injury to a specified area of unknown cause.

A CIR was submitted to the Director to report the receipt of a written complaint letter received by the home but the written complaint letter was not provided to the Director.

WN #13: 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).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's SDM was immediately notified upon becoming aware of an alleged, suspected or witnessed incident of abuse of the resident that resulted in physical injury or pain to the residents, or caused distress to the resident that could potentially detrimental to the resident's health or well-being (s.97(1)(a)). The licensee also has failed to ensure that the resident and resident's SDM were notified of the results of the alleged abuse or neglect investigation immediately upon the completion(s.97(2).

Related to Intake #001456-15:

Review of a Critical Incident Report (CIR) indicated several residents were involved in allegations of staff to resident verbal/emotional abuse and incompetent care by S#128. Not all of the residents involved were identified on the CIR.

Review of the home's investigation indicated that although 15 Residents were involved in the allegations, there was no documented evidence that all the SDM's were notified of the allegations.

An interview with the Administrator revealed that he notified the residents that were competent (not the SDM) but could not recall if the SDM's of the resident who were not competent were notified. The Administrator could not provide documented evidence to indicate which competent residents were notified and could not provide documented evidence to indicate which residents and/or SDM's were notified of the outcome of the investigation(#607).

2. Related to log #012651-15 & 02759-15:

A critical incident report (CIR) was received on a specified date for allegation of improper/incompetent treatment of a resident that resulted in harm or risk of harm to the resident. The CIR indicated that on the same day, Resident #047 reported that S#115 was physically abusive towards the resident. The CIR indicated the SDM was contacted.

Review of the health record of Resident #047, interview of staff and review of the home's investigation indicated an email was sent to the SDM of Resident #047 to report the incident, the day after the incident had occurred.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 103. Complaints — reporting certain matters to Director

Specifically failed to comply with the following:

s. 103. (1) Every licensee of a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). O. Reg. 79/10, s. 103 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a long-term care home who receives a written complaint with respect to a matter that the licensee reports or reported to the Director under section 24 of the Act shall submit a copy of the complaint to the Director along with a written report documenting the response the licensee made to the complainant under subsection 101 (1). The licensee shall comply with subsection (1) immediately upon completing the licensee's investigation into the complaint, or at an earlier date if required by the Director(2).

Related to Intake #001456-15:

A Critical Incident Report (CIR) was submitted to the Director, on a specified date regarding a 'complaint' relating to S#128 being both verbally and emotionally abusive to residents, as well provided incompetent care to 15 residents on a specified date.

An interview with the Administrator indicated a copy of the written complaint letter was sent via email to the Central Intake Assessment and Triage Team (CIATT), but had no documented evidence of this.

A review of the home's records and interview with Central Intake Assessment and Triage Team (CIATT) had no documented evidence to indicate a copy of the written complaint letter submitted to the home was sent to the Director upon receipt of the complaint or after the investigations into the complaint(#607).

2. The licensee has failed to ensure that a copy of the corresponding written report documenting the response the licensee made to the complainant was submitted to the Director.

Related to log # 006422-14:

A critical incident report (CIR) was received on a specified date regarding a written complaint received by the home (the day before) from the SDM of Resident #043 related to concerns of continence care. The CIR included a copy of the complaint letter.

Interview of Administrator indicated a written response was provided to the complainant but the home's response to the complainant was not provided to the Director.

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

Issued on this 1st day of February, 2016

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

Original report signed by the inspector.