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
Mar 2, 2020	2020_792659_0005	024452-19, 001053-20, 002552-20	Critical Incident System

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 Listowel Nursing Home
710 Reserve Avenue South LISTOWEL ON N4W 2L1

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

JANETM EVANS (659)

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): February 11, 12, 13 and 14, 2020.

The following intakes were included in this inspection:
Log #001053-20\CI 2664-000002-20 related to alleged neglect of a resident.
Log #024452-19\CI 2664-000031-19 related to a resident fall with injury.
Log #002552-20\CI 2664-000003-20 related to a resident fall with injury.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), a Registered nurse (RN), a Registered Practical Nurses (RPN), Personal Support Workers (PSW), a Physiotherapist and residents.

During the inspection observations were made of staff to resident interactions, provision of care and safety interventions. A review of relevant records and policies was completed.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Prevention of Abuse, Neglect and Retaliation

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	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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written plan of care for resident #003 which set out the planned care for the resident.

A Critical Incident (CI) was submitted to the Ministry of Long Term Care (MLTC) which documented resident #003 had sustained a fall and was transferred to hospital for assessment.

The care plan for resident #003, documented safety interventions for fall prevention, however there was no documentation related to specified fall injury prevention equipment.

There was no task or Point of Care (POC) documentation related to the use of the use of the specified fall injury prevention equipment.

On a specified date, resident #003 sustained an unwitnessed fall and they were transferred to hospital where they were assessed to have an injury.

Physiotherapist #114 said that they documented a communication note and progress note and they thought they had spoken with the DOC about a trial of specified fall injury prevention equipment for resident #003.

PSWs #102, #103, #104 and #106 said they usually look at the care plan or Kardex for information on resident care, they also may receive care updates during shift report. PSW #105 said when they checked resident #003's plan of care, they did not see anything documented about specified fall injury prevention equipment.

DOC #100 said resident #003 had been on a trial of the specified fall injury prevention equipment but the resident was not compliant with this. The DOC said the use of this equipment had been documented in Point Click Care (PCC) communication for staff as it was a trial. They acknowledged that the communication notes on PCC were not part of the resident's plan of care and that the fall injury prevention equipment should have been documented in resident #003's plan of care but it was not.

2. The licensee has failed to ensure that resident #001 was reassessed and the plan of care was reviewed and revised when the resident's care needs changed or care set out in the plan of care was no longer necessary.

A CI was submitted to the MLTC related to possible neglect of resident #001.

The plan of care for resident #001, documented the resident was to be toileted at specified times.

Observations completed on three specified dates, did not show the resident was toileted at a specified time.

PSW #106, #107 and #108 acknowledged that resident #001 was not toileted at the specified time. PSW #103 and #104 stated resident #001 was no longer toileted. Four PSW's stated that resident # 001's health status had deteriorated.

RN #110 stated resident #001 was supposed to be toileted at specified times. PSWs were supposed to notify them if a resident's status changed as they completed assessments and would update the plan of care.

DOC #100 stated that resident #001's health status had declined and that the plan of care had not been updated.

3. The licensee has failed to ensure that resident #002 was reassessed and the plan of

care reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

Resident #002 was assessed to require two staff physical assistance for specified activities of daily living (ADL's).

The plan of care for resident #002 documented extensive assistance of two staff for the specified ADL's.

Observations completed showed one person physical assistance was provided to resident #002 for the specified ADL's.

PSW #105 said resident #002 required assistance of one person for the specified ADL's as their health status had improved.

DOC #100 said resident #002 was a one person assist for ADL's. They acknowledged they had not updated the resident's plan of care to reflect the change in resident #002's care needs.

The licensee failed to ensure that the written plan of care for resident #003 set out the planned care for the resident related to the use of the specified fall injury prevention equipment. In addition to this, the licensee had failed to ensure that residents #001 and #002 plan of care reviewed and revised when the resident's care needs changed or care set out in the plan was no longer necessary.

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 there is a written plan of care for resident #003 that sets out the planned care related to the use of fall injury prevention equipment and to ensure that that resident #001 and #002 are reassessed and the plan of care is reviewed and revised when the resident's care needs change or care set out in the plan of care was no longer necessary, 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 resident #001 was free from neglect by the licensee or staff in the home.

A CI was submitted to the MLTC, related to alleged neglect of resident #001.

Neglect is defined in O. Reg. 79/10, as the failure to provide a resident with the care or assistance required for health, safety or well-being, and includes inaction that jeopardizes the health, safety or well-being of one or more residents.

The home's investigation documented that on a specified date, during rounds, resident #001 was found on the toilet, where they had been left by evening staff. The documentation stated that the resident was assessed to have altered skin integrity.

PSWs #102 and #103 said they put resident #001 on the toilet and left them there when they left at the end of their shift. PSW #102 acknowledged they had forgotten to inform the oncoming staff to check on resident #001. PSW #102 and DOC #100 said that leaving someone on the toilet for an hour or more was neglect.

The licensee has failed to ensure that resident #001 was free from neglect by the licensee or 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 resident #001 and all other residents are free from neglect by the licensee or staff in the home, 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 the person who had 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: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

A CI was submitted to the MLTC on a specified date, related to possible neglect of resident #001, which took place one day prior.

On a specified date and time, night staff discovered that resident #001 had been left unattended on the toilet by evening staff. The RN on duty did not immediately report the incident.

DOC # 100 said that they believed this was an incident of neglect. After hours, the RN should have immediately notified the on call manager and they did not.

The licensee failed to ensure that the person who had 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: Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm. [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 all staff of the home are aware and trained of the requirement to immediately report to the Director, abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm. In addition to this the licensee will ensure staff are trained on the use of the afterhours reporting number and where this can be located in the home, to be implemented voluntarily.

Issued on this 2nd day of March, 2020

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

Original report signed by the inspector.