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

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 28, 2020	2020_834524_0012	013029-20, 014411-20	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 on Mary Bucke
4 Mary Bucke Street ST. THOMAS ON N5R 5J6

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

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): July 20, 21 and 22, 2020.

The following Critical Incident System (CIS) intakes were completed within this inspection:
Log #013029-20 / CIS 2627-000008-20 related to allegations of resident to resident abuse
Log #014411-20 / CIS 2627-000009-20 related to falls prevention and management.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, a Registered Practical Nurse, Personal Support Workers and residents.

The inspector(s) also observed resident care provisions, resident and staff interactions, reviewed clinical records including assessments and care planning interventions for identified residents, the home's investigation notes and policies and procedures related to this inspection.

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

During the course of this inspection, Non-Compliances were issued.
- **2 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 O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on, at a minimum, an interdisciplinary assessment of resident #001’s behaviour patterns, including any identified responsive behaviours.

This inspection was initiated as a result of a Critical Incident System (CIS) report submitted to the Ministry of Long-Term Care (MLTC) regarding an incident of resident to resident abuse on a specific date. Review of the CIS identified that resident #002 had wandered into resident #001’s room. Personal Support Worker #107 had witnessed resident #001 initiating a specific behaviour towards resident #002. PSW #107 intervened and resident #002 was removed from the room. A previous critical incident report was submitted to the MLTC whereby staff witnessed resident #001 initiating a specific behaviour towards resident #005.

Review of resident #001's progress notes on Point Click Care for identified dates showed the resident engaged in specific behaviours on different occasions, which was documented by staff.

Record review of the most recent plan of care on Point Click Care for resident #001 indicated there was no focus statement, goals or interventions with respect to the resident's identified responsive behaviours.

The Director of Care (DOC) #103 verified the Behaviour Support Ontario (BSO) team was involved and had initiated a monitoring record on a specific date, related to the responsive behaviour. Staff interview with the Director of Care #103 and Registered Practical Nurse #101 acknowledged the absence of a focus statement, goals and interventions related to the identified responsive behaviours and that it was the home’s expectation that there should be.

The licensee had failed to ensure that the plan of care was based on, at a minimum, an interdisciplinary assessment of resident #001’s behaviour patterns, including the identified responsive behaviours. [s. 26. (3) 5.]

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 is based on, at a minimum, an interdisciplinary assessment of the residents behaviour patterns, including any identified responsive behaviours, to be implemented voluntarily.

WN #2: 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 staff used safe transferring and positioning devices or techniques when assisting resident #003.

This inspection was initiated as a result of a Critical Incident System (CIS) report submitted to the Ministry of Long-Term Care (MLTC) on a specific date, related to a fall incident where resident #003 was injured while being transported in their Personal Assistive Services Device (PASD).

Review of the CIS report identified that on a specific date staff responded to a Code Care fall on a unit. When staff responded they found resident #003 was on the floor. Resident #003 told the registered nurse that “I don’t know how I fell”. Personal Support Worker (PSW) #106 that was transporting the resident reported they were assisting the resident and suddenly the resident was out of their PASD and on the floor. The resident was sent for assessment and was diagnosed with multiple injuries.

Review of the Minimum Data Set (MDS) quarterly review assessment and the Resident Assessment Protocol (RAP) notes documented that resident #003 used an identified PASD with staff assistance to "locomote on/off unit.”

In an interview on a specific date, Personal Support Worker (PSW) #104 said that resident #003 sometimes asked for assistance if they were tired, otherwise they would

locomote around the home independently with their PASD. PSW #104 said that they had witnessed the fall incident on the identified date.

In an interview on a specific date, Executive Director (ED) #100 stated that on occasion if resident #003 was tired, staff would assist to locomote the resident with their identified PASD. ED #100 said that, in response to the incident, new education was placed on Surge Learning related to assisting residents and all staff were required to review and complete the competency assessment.

In an interview on a specific date, Director of Care (DOC) #103 acknowledged that there were safety risks to a resident if they were transported with an identified PASD without a specific intervention in place. Inspector #524 asked DOC #103 if staff used safe transferring techniques when resident #003 was transported on a specific date. DOC #103 said that they would say no because staff needed to do a physical check of the environment. DOC #103 said that moving forward staff may no longer assist a resident in the identified PASD unless the specific interventions were in place.

The licensee had failed to ensure that staff used safe transferring and positioning devices or techniques while resident #003 was being assisted resulting in injury. [s. 36.]

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 devices or techniques when assisting residents, to be implemented voluntarily.

Issued on this 30th day of July, 2020

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

Original report signed by the inspector.