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

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 4, 2019	2019_785732_0013	006794-18, 008435-18, 009415-18, 009685-18, 011254-18, 014369-18, 017379-18, 024821-18, 032678-18, 003555-19	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 McLaughlin Road
114 McLaughlin Road LINDSAY ON K9V 6L1

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

EMILY BROOKS (732), AMANDA NIXON (148)

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): May 27-31, 2019

The following intakes with associated critical incident reports (CIR) were completed during this Critical Incident System inspection:

Log #008435-18 (CIR #2916-000012-18) related to visitor to resident alleged abuse

Log #003555-19 (CIR #2916-000006-19) related to staff to resident alleged abuse

Log #017379-18 (CIR #2916-000018-18), Log #024821-18 (CIR #2916-000023-18), Log #011254-18 (CIR #2916-000016-18), Log #009415-18 (CIR #2916-000014-18), and Log #006794-18 (CIR #2916-000008-18) related to falls

Log #014369-18 (CIR #2916-000017-18) and Log #032678-18 (CIR #2916-000030-18) related to medication

Log #009685-18 (2916-000015-18) related to nutrition and dining

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), the Food Service Manager (FSM), a food service worker (FSW), the Activity Director (AD), a Registered Dietician (RD), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.

In addition, the inspectors reviewed critical incident reports (CIR), health care records, staff schedules, medication incident reports as applicable, and documents related to fall incidents. The inspectors observed resident care areas, including bedrooms, medication rooms, and dining rooms, and staff to resident interactions.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints

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

5 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care of resident #004 collaborate with each other in the assessment of the resident so that their assessments are integrated and consistent with and complement each other.

On a specified date, RN #116 submitted a Nutrition Referral to the Registered Dietitian (RD), indicating that resident #004’s intake had decreased, suspecting a swallowing issue. Four days later, the RD conducted an assessment and initiated minced texture related to delayed swallow.

In review of the health care record, a progress note on the following day, written by RN #118, described that resident #004 had a suspected acute medical incident, whereby the resident’s ability to swallow was affected. A progress note nine days later from RN #116 noted the resident had symptoms that may impact on food and fluid intake.

Six days after the medical incident, a Nutrition Referral was submitted by RN #116 describing that resident #004 had a choking episode potentially related to pocketing food and the provision of thin fluids. A progress note of the same day, indicated that the resident required intervention, whereby small pieces of food were dislodged.

The next day, the Resident Care Coordinator #117 and the FSM met with the resident’s substitute decision maker (SDM) regarding the recent choking incident and swallowing issues and the family requested puree texture. The implementation of thickened fluids was discussed; the resident was to remain on thin fluids.

Three days later, a progress note written by RN #116 described the resident as having difficulty with fluids, noting coughing and fluid dripping from the mouth. An observation by the FSM on the same date, described the resident as having no swallowing issues on puree texture and thin fluids.

The next day, a subsequent choking episode occurred. A progress note of the same date by RN #116 indicated that the resident was struggling to swallow and required staff assistance to clear mouth of food and fluid. The note further described the resident as having symptoms related to the acute medical incident occurring twenty days priors. The RN noted a discussion with the resident's SDM to which thickened fluids were requested by the family.

The RD was on site at the home at the time whereby the resident was having changes in swallowing ability, however was not on site at the time of the choking episodes. In an interview with the RD, it was reported that the RD was not made aware of the resident's acute medical incident and related symptoms prior to the RD's leave. The RD reported that upon return from leave, resident #004 was assessed, whereby the RD was made aware of the previous choking incidents. In a discussion with the RD, it was reported that the home can access dietetic services through the home's contract service and also may access community speech language pathology services for swallow assessments.

In the matter of resident #004, regarding changes in swallowing ability and reported choking incidents, staff involved in the different aspects of care, specific to nutritional care, did not collaborate with each other in the assessment of the resident.

(Log 009685-18) [s. 6. (4) (a)]

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 and others involved in different aspects of resident care, collaborate with each other in the assessment of the resident so that their assessments are integrated and consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system can be easily seen, accessed and used by residents, staff, and visitors at all times.

Two critical incident reports (CIR's) were submitted to the Director, both describing that resident #007 had a fall that caused an injury for which resident #007 was taken to hospital and that resulted in a significant change in resident #007's health status. On May 29, 2019, during observation of resident #007 in their bedroom, Inspector #732 was unable to see resident #007's call bell. Inspector #732 observed that the call bell was plugged into the wall behind resident #007's bed and that the cord was hanging straight down. Inspector #732 followed the cord and observed the call bell resting on the bed frame, behind the head of the bed, close to the ground. The head of the bed was up at a 45 degree angle and resident #007 was resting in the bed. Resident #007 was unable to access the call bell.

On May 29, 2019, Inspector #732 observed resident #009 sitting in their wheelchair. Inspector #732 observed resident #009's call bell laying on the floor, directly behind the resident. Resident #009 told Inspector #732 that they would like to get back into bed as they were having pain. Inspector #732 asked resident #009 if they could reach their call bell to ring for assistance. Resident #009 attempted to reach for the call bell, but was unable to obtain it.

Review of resident #007 and resident #009's care plan indicated that the call bell should be within easy reach at all times for both residents. In an interview with PSW #114, they told Inspector #732 that all resident call bells should be within reach of a resident.

The licensee has failed to ensure that resident #007 and resident #009 had access to their call bells at all times. [s. 17. (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 the resident-staff communication and response system can be easily seen, accessed and used by residents, staff, and visitors at all times, to be implemented voluntarily.

WN #3: 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 a written complaint received concerning the care of resident #004 was immediately forwarded to the Director.

The substitute decision maker (SDM) for resident #004 wrote a letter of complaint on a specified date, concerning the dietary care of resident #004. Specifically, the letter indicated that the SDM was not informed of assessments conducted and that the resident was not receiving the correct fluid consistency.

The complaint letter was received by Executive Director #004. Ten days later, ED #005 wrote a response to the complaint and on the following day, submitted the complaint letter to the Director by way of a critical incident report for improper/incompetent care. The written complaint was submitted to the Director eleven days after the licensee received the complaint.

(Log 009685-18) [s. 22. (1)]

WN #4: 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 a report was made immediately to the Director when there was reasonable grounds to suspect that unlawful conduct resulted in risk of harm to residents.

A critical incident report (CIR) was submitted to the Director which described that PSW #108 suspected RN #107 was in possession of resident medications outside of the long-term care home.

PSW #108 reported their suspicions to the DOC on a specified date. The next day, PSW #108 provided ED #100 photos of containers with varying medications in them. That same day, ED #100 initiated an investigation and called the police as theft was suspected. The CIR was not submitted to the Director until 21 days later. [s. 24. (1) 3.]

WN #5: 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. (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 resident #003 was notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation.

In accordance with section 2 of the LTCHA, 2007, verbal abuse means any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident. Physical abuse means the use of physical force by anyone other than a resident that causes physical injury or pain. As described by section 23 (1) of the LTCHA, 2007, the licensee shall investigate every incident of alleged resident abuse.

On a specified date, resident #003 reported that during care PSW #111 had made inappropriate comments and that the PSW was physically rough with the resident causing pain.

In response to the alleged abuse, the DOC initiated an investigation. The investigation concluded approximately one month later. Inspector #148 interviewed resident #003, who indicated that the resident had not been informed of the results of the investigation. The DOC and ED reported that the resident was not informed of the results of the investigation upon the completion of the investigation.

(Log 003555-19) [s. 97. (2)]

Issued on this 6th day of June, 2019

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

Original report signed by the inspector.