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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Apr 14, 2015	2015_284545_0005	O-001483-15	Complaint

Licensee/Titulaire de permis

RELIGIOUS HOSPITALERS OF ST. JOSEPH OF CORNWALL, ONTARIO
14 York St CORNWALL ON K6J 5T2

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

ST JOSEPH'S CONTINUING CARE CENTRE
14 YORK STREET CORNWALL ON K6J 5T2

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

ANGELE ALBERT-RITCHIE (545)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 11 and 12, 2015

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

The inspector also reviewed the home's Abuse Policy and Procedures, staff schedule, investigation report, residents' health records including, Plans of Care and other documentation within the home, toured residential areas, Resident #001's room, including bathroom and a common bathroom, and observed resident care provision and services, including interaction between staff and others who provide care to Resident #001, as well as other residents.

The following Inspection Protocols were used during this inspection:
Hospitalization and Change in Condition
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours

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	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. (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. (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 comply with LTCHA 2007, S.O. 2007, c.8, s. 6 (1) in that the licensee did not ensure that there is a written plan of care for each resident that sets out, the planned care for the resident; the goals the care is intended to achieve; and clear directions to staff and others who provide direct care to the resident.

Resident #001 has multiple deficits; including visual, hearing and cognitive and is wheelchair bound. The Resident wanders on the unit.

A family member indicated to the Inspector that the home had installed a Roam Alert on the Resident's chair in the fall of 2014 and not informed the family until December 25, 2014 when a staff member told them that the Resident had been found off the unit on more than one occasion and a roam alert was initiated as a safety measure.

The Home's Wandering Resident Alert Bracelets policy number 11-a-174 was reviewed by the Inspector. It is indicated that for safety reasons, an alert bracelet will be applied to confused/wandering residents and under Policy, item 1.3 it states that the home will "notify the family of the requirement and procedure". Under Procedure, item 1.3 states that the home will "develop and document a Nursing Care Plan to manage the resident's tendency to wander".

On March 11, 2015 during an interview with RPN #S101, she indicated she was unsure of when a Roam Alert bracelet was installed on Resident #001's wheelchair; added that it had been removed on a specific date in February, 2015 as it was required for another Resident who was at higher risk of wandering. The RPN was unable to find

documentation that set out the planned care for the Roam Alert bracelet; the goals the care was intended to achieve; and clear directions to staff and others who provided direct care to the resident.

In a review of the Resident's health record, a note dated a specific date in September, 2014 indicated that Resident #001 had been found outside the home on the weekend and in discussion with the Director of Care, it was decided that a Roam Alert would be applied to the Resident's wheelchair.

The Director of Care (DOC) indicated during an interview on March 12, 2015 that a Roam Alert was applied to Resident #001. The DOC indicated that staff had found the Resident on the Main Floor near the entrance doors of the home, but no one had seen how the Resident had left the unit. She stated that the Roam Alert was applied as a safety measure to prevent anyone from removing the Resident from the unit, without staff knowledge. The DOC indicated that the staff were expected to inform the family when the Wandering Resident Alert Bracelet (Roam Alert) was applied, as well as update the Plan of Care to include the planned care, goals the care was intended to achieve and clear direction to staff and others who provided care to the Resident. [s. 6. (1)]

2. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 6 (7) in that the licensee did not ensure that the care set out in the plan of care provided to the resident as specified in the plan.

On March 11, 2015 during an interview with RN #S100, she indicated that direct care staff did not have access to Residents' electronic plans of care; added that the registered staff updated and printed the most recent care plans and made them available in a black binder which is left at the Nursing Station for easy access to direct care staff.

In a review of Resident #001's most recent plan of care dated a specific date in November, 2014 it was noted that pages 1, 2 and 3 were missing. It was documented that the Resident required assistance of 2 staff for transfers, including for transfers to the toilet and shower. The Transfer Instruction sign above the Resident's bed indicated that the Resident was a 2-person pivot transfer with a specific date in December, 2012.

On March 11, 2015 the Inspector observed staff member #S102 transfer Resident #001 by himself from the wheelchair to the toilet.

On March 11 and 12, 2015, the Inspector interviewed staff members #S102, #S104 and

#S103. All three indicated that they provided care to Resident #001 and did a 1-person transfer to and from the toilet, and to and from the bed; added that the Resident was an easy transfer, as could weight bear and could hold on to the grab bar at the toilet or the bedrails on the bed.

During an interview with RPN #S101 on March 11, 2015, she indicated she was the Resident's case manager and responsible for updating the plan of care; added she thought Resident #001 was a 1-person transfer. After checking the plan of care, the RPN clarified that the Resident was in fact a 2-person transfer. She indicated that if the direct care staff would have informed her that the Resident no longer required a 2-person transfer, she would have requested an assessment by the physiotherapy-assistant to review the transfer.

On March 12, 2015 the Director of Care indicated that Resident #001 was a 2-person transfer because of the Resident's unpredictability. She indicated that a 2-person transfer was required for the safety of the Resident and the staff; added that if the direct care staff felt a reassessment of the transfer was required, they were expected to submit a request online to the therapist. [s. 6. (7)]

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 there is a written plan of care for Resident #001 that sets out, the planned care , the goals the care is intended to achieve, clear direction to staff and others who provide direct care to Resident #001, as well as ensuring that the care set out in the plan of care for transfers is provided as specified in the plan, to be implemented voluntarily.

WN #2: 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. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, S.O. 2007, c.8, s. 20 (2) (b) in that the licensee did not ensure that the policy to promote zero tolerance of abuse and neglect of residents clearly set out what constitutes abuse and neglect.

Policy # 4-a-1 entitled Zero Tolerance of Abuse and/or Neglect of Residents and Patients (revised Feb. 12, 2014) was provided to the Inspector by the Executive Director upon request for the home's policy to promote zero tolerance of abuse and neglect of residents.

A review of the Abuse policy demonstrates that the policy does not clearly set out what constitutes abuse and neglect in that:

- the definition of "emotional abuse" does not clearly set out that emotional abuse includes any insulting, humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident, or any threatening or intimidating

gestures, actions, behaviour or remarks by a resident that causes alarm or fear to another resident where the resident performing the gestures, actions, behaviour or remarks understands and appreciates their consequences, as defined by O.Reg 79/10, 2 (1).

- the definition of "financial abuse" does not clearly set out that financial abuse includes any misappropriation or misuse of a resident's money or property, as defined by O.Reg 79/10, 2 (1).

- the definition of "physical abuse" does not clearly set out that physical abuse includes physical force by anyone, does not include the administering or withholding of a drug for an inappropriate purpose and provides no distinction between resident to resident physical abuse and physical abuse by anyone, as defined by O.Reg 79/10, 2 (1).

- the definition of "sexual abuse" does not clearly set out that sexual abuse includes any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member, or any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member

- the definition of "verbal abuse" does not clearly set out that verbal abuse includes 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, or any form of verbal communication of a threatening or intimidating nature made by a resident that leads another resident to fear for his or her safety where the resident making the communication understands and appreciates its consequences

- the definition of neglect does not include the failure to provide treatment, care or assistance and does not include inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents, as defined by O.Reg 79/10, 5. [s. 20. (2)]

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 home's policy to promote zero tolerance of abuse and neglect of residents clearly set out what constitutes abuse and neglect, to be implemented voluntarily.

WN #3: 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 comply with LTCHA 2007, S.O. 2007, c.8, s. 23 (1) (a) in that the licensee did not ensure that every alleged, suspected or witnessed incident that the licensee knows of, or is reported, is immediately investigated.

An alleged physical abuse was reported to the Ministry of Health and Long Term Care on a specific date in December, 2014. In a review of the Critical Incident Report (CI) submitted by the home, it was noted that the Executive Director would commence the investigation of the alleged physical abuse of Resident #001, with the Director of Care on four (4) days post incident. It was indicated in the CI that a family member contacted the home from the Emergency Department indicating that Resident #001's had been assessed by the Emergency Department Physician and they were advised that the bruising on the Resident's limb was consistent with a hand print.

On March 11, 2015, during an interview with RN #S100, she indicated that she was the Charge Nurse working the day shift (07:00 to 15:00) the day the incident occurred, as well as the following day. She indicated that she assessed Resident #001 immediately following the reporting of the incident and found extensive bruising on the Resident's limb measuring approximately 6-8 inches, including three round areas and a linear area. The RN indicated that following the call from the family indicating that the bruising was consistent with a hand print, she contacted the Executive Director who was on-call to report the alleged abuse. The RN indicated that the alleged incident was not immediately investigated.

During an interview with the Executive Director on March 12, 2014, she indicated that she became aware of the alleged abuse of Resident #001 when RN #100 contacted her by telephone, which was approximately two (2) hours following the reporting of the bruising, and immediately after the family called to indicate that the bruising was consistent with a hand print. She indicated that she immediately came to the home, submitted a Critical Incident to the Ministry and contacted the Police to report the alleged abuse. The Executive Director indicated that she started the investigation of the alleged abuse on a specific date in December, 2014, five (5) days following the occurrence of the incident, when she discussed the Resident's medical condition with the home's physician and interviewed two staff members.

As such, the licensee did not ensure that the alleged incident, reported to the home on December 25, 2014 at 14:20, was immediately investigated. [s. 23. (1) (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 every alleged, suspected or witnessed incident that the licensee knows of, or is reported, is immediately investigated, to be implemented voluntarily.

Issued on this 15th day of April, 2015

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

Original report signed by the inspector.