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
Jan 5, 2016	2015_347197_0039	032451-15	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

JESSICA PATTISON (197)

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): November 24 and 25, 2015

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Personal Support Worker (PSW) Supervisor, the Registered Dietitian, the Food Service Supervisor, a Registered Nurse, a Registered Practical Nurse, Personal Support Workers, a Dietary Aide and a Resident.

The inspector also reviewed resident health care records, the home's policies related to abuse and responsive behaviours and observed resident care, including dining service.

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

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

2 WN(s)
1 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).

Findings/Faits saillants :

1. The licensee has failed to comply with LTCHA 2007, s. 6(1)(c) in that the plan of care for a resident does not set out clear directions to staff and others who provide direct care to the resident.

The current care plan for Resident #002 outlines specific behavioural symptoms and interventions, as well as the resident's ADL (Activity of Daily Living) function. Specifically, the care plan stated that when the resident is resistive to ADLs, staff are to remind the resident that there are consequences. Staff are to be firm with the resident. The resident may leave the table, but will then return. Staff are to cue the resident to eat until the meal is completed."

Staff interviews indicated the following:
RN #102 stated that sometimes consequences are used with Resident #002. Other staff just give and give and are kind-hearted, but there have to be limits and consequences.
PSW #103 stated that Resident #002 eats better when staff sit with the resident but he/she can usually eat on their own. She said they may be looking at providing more assistance with feeding as the resident does consume more when assistance is provided.
PSW #104 stated that she was told that she could not provide feeding assistance to Resident #002 and this went on for two shifts, at which point she then went to the DOC and PSW Supervisor. The DOC indicated to the PSW that staff could provide feeding assistance to the resident and she communicated this to other PSW staff and they have been providing assistance since then.
PSW #105 indicated that she tells the resident to come have a seat and if the resident says no, then she lets him/her go and the resident usually comes back.
PSW #106 stated that there was some confusion when the resident started leaving the dining room as to whether staff should be providing feeding assistance. She stated currently they are offering to feed Resident #002 and the resident will often accept the help. PSW #106 indicated that she feels it's safer for staff to feed the Resident #002. She stated that she has not been directed to take anything away from the resident if he/she does not comply with care.
RPN #101 indicated that Resident #002 is capable of self-feeding and feels that leaving the dining room and not eating is behavioural. She stated that she had stood behind the resident's chair and held it in place until the resident ate the meal and this seemed to work. She stated that other staff just feed the resident which she doesn't think is beneficial. She stated she did not have direction or discussion with any other staff

member to stand behind the resident's chair, she just wanted to try it to see if it would work.

The progress notes were reviewed and RPN #101 charted on October 27, 2015 that she held Resident #002's chair in place until the resident was finished eating the meal.

Resident #002 was observed at two lunch meals during the inspection. On November 24, 2015, Resident #002 was fed the entire lunch meal by a staff member and the resident ate all of the meal. The staff member did not cue the resident to self-feed during this meal. On November 25, 2015, a PSW sat with Resident #002 and cued the resident to self-feed and also provided some feeding assistance when necessary. Again, Resident #002 ate all of the lunch meal.

Resident #002's plan of care did not provide clear direction to staff on how to provide care to the resident at meal times and staff are not consistent in their approach to get the resident to eat. [s. 6. (1) (c)]

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 for Resident #002 sets out clear directions to staff and others who provide direct care the resident, 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. (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 comply with LTCHA 2007, s. 20(1) in that the home's written policy that promotes zero tolerance of abuse and neglect of residents was not complied with.

The home's policy "Zero Tolerance of Abuse and/or Neglect of Residents and Patients" last reviewed May 6, 2015, states the following:

- All employees and affiliated personnel; including people who work in the Centre, and those who provide professional services in the areas of health or social services work to residents and patients and/or the licensee are required to fulfill their moral and/or legal obligation to report any incident of resident/patient abuse immediately to their Manager/Designate.

On a specified date during a telephone interview, a staff member indicated witnessing an incident of staff to resident abuse. The exact date of the incident could not be recalled, but she stated it was the 1500-2300h shift and that another staff member pulled Resident #002 by the arm into the dining room and "slammed" the resident into a chair. The same staff member was then alleged to stand behind the resident's chair preventing the resident from getting up. The resident was stated to be screaming while this was happening. When asked if the incident was reported to the home, the staff member stated no, but that it should have been. The witnessing staff member further indicated being scared to report the incident because of what happened when a previous incident was reported.

The allegation of staff to resident abuse was reported to the Director of Care by Inspector #197. The Director of Care submitted a Critical Incident Report the same day, indicating that the home would be conducting an investigation. On a later date, the Critical Incident Report was updated to say that the home could not verify the allegation of abuse. [s. 20. (1)]

Issued on this 5th day of January, 2016

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

Original report signed by the inspector.