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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Jul 18, 2016	2016_381592_0016	010590-16, 016285-16, 019871-16, 016681-16	Critical Incident System

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

MELANIE SARRAZIN (592)

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 5, 6, 7, 11, 12 and 13, 2016

During the course of the inspection, the inspector conducted a total of four Critical Incidents inspections Log#: 010590-16 (staff to resident alleged abuse), 016285-16 (resident to resident alleged abuse), 019871-16 (resident to resident alleged abuse) and 016681-16 (resident to resident alleged abuse).

During the course of the inspection, the inspector(s) spoke with the home's Executive Director, the Director of Care (DOC), the Director of Nursing (DON), the Program Support Director, the Patient and Resident Relation Adviser, the Infection Control/Occupational Health and Safety Adviser, Registered Nurse (RN), Registered Practical Nurse (RPN), Housekeeping aide, Behaviour Support Worker (BSO), Personal Support Worker (PSW) and residents. During the course of this inspection, the inspector observed the delivery of Resident care and services, reviewed Residents' health care records and reviewed the home policies and procedures.

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.

- **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).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a written plan of care for resident #006 that sets the planned care for the resident; (Log #016681-16)

A review of resident #006's health care record indicated that resident #006 was admitted on a specified month in 2015 with cognitive impairment and other medical issues.

A Critical Incident was submitted to the Ministry of Health and Long Term Care regarding a resident to resident alleged abuse between resident #006 and resident #005.

A review of the resident #006's progress notes indicated that on a specified date in May 2016, at a specific time, resident #006 went across the hallway into co-resident #005's room as resident was calling out for staff members. Resident #006 attempted to choke resident #005. When resident #005 yelled louder, resident #006 struck resident #005 on a specific body part causing a laceration with bruising. On the following day of the incident, resident #005 was moved to another room, away from resident #006's room.

On July 12, 2016, in an interview with PSW #113, he told Inspector #592 that resident #006 was known to get upset and agitated upon excessive noise and that resident #005 who was residing across resident #006's room was often calling out for staff members. PSW #113 told Inspector #592 that previous to May 2016 incident, he had reported several times to different registered staff members that resident #006 did threaten resident #005 by telling the staff that he/she would hurt the resident if he/she continued to yell and disturb him/her. PSW #113 told Inspector #592 that there was no specific interventions put in place after reporting these incidents to registered staff other than redirecting resident #006 to his/her room and calm him/her down.

On July 12, 2016, in an interview with PSW #116, he told Inspector #592 that resident #006 was known to not like excessive noise and when resident #005 yelled , it would get resident #006 upset and then the staff would redirect resident #006 to his/her room and try to calm him/her down. He further told Inspector #592 that previous to May 2016 incident, resident #006's room was across resident #005's room and that several times when resident #005 would yell for help, resident #006 would come out of his room and ask "who is doing all that noise" and he/she would shut resident #005 's door .

Upon a review of the resident #006's health record, it was noted that on a specific date in November 2015, resident #006 was upset with co-resident #005 who resided across the

hallway. Resident #006 went and shut resident #005's door and told staff members that resident #005's yelling was disturbing him/her greatly and told staff that he/she would punch resident #005.
The documentation further indicates that six days later, resident #006 was getting upset with co-resident #005 across the hallway because resident #005 was yelling. As well, it was noted that on a specified date in June 2016, resident #006 was upset at supper time with another co-resident at next table because the co-resident was talking very loud and resident #006 was getting agitated.

Upon a review of the documentation in the current written plan of care for Resident #006, it indicates that resident #006 prefers the solitary of being alone in his room. Resident #006's written plan of care did not set out the planned care for behaviours related to his/her agitation when exposed to excessive noise.

In an interview with the DOC, she told Inspector #592 that the plan of care is updated quarterly and as needed for all residents by the RPN with the feedback of PSW's. She further told Inspector #592 that the planned of care for resident #006 related to his/her behaviours should have been documented in his/her written plan of care to ensure that staff members are aware of the interventions to manage his/her behaviours. [s. 6. (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 the written plan of care for resident #006 sets the planned care for resident #006 who is exhibiting behaviours related to excessive noise, to be implemented voluntarily.

WN #2: 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 person who has reasonable grounds to suspect that abuse of a resident by anyone has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director. (Log# 016285-16)

According to O.Reg.79/10, s.2.(1) " Physical abuse is defined as the use of physical force by a resident that causes physical injury to another resident"

Upon a review of the resident #003's health care record, it was observed that on a specified date in May 2016 at a specific time, resident #002 was found on the floor outside of his/her bedroom in the hallway. Resident #002 was lying in supine position, shouting that a resident had pushed him/her down. Resident #002 told staff members that he/she was trying to get into her room but co-resident #003 would not allow him/her to, leading to an altercation between both residents, resulting in resident #003 pushing resident #002 causing him/her to fall. The fall resulted in a large contusion to the back of resident's skull and an injury to a specific body part. Resident #002 was immediately sent to the hospital where she was diagnosed with a an injury of a specific body part.

On that same evening, Registered Nurse #109 reported the incident to the on call Manager which was the Director of Nursing at the time of the incident. The Director of Nursing reported to the Director of Care on the next day, who then, notified through the

Critical Incident System, the Director.

During an interview with the Director of Nursing, she told Inspector #592 that she did not inform the Director, under the LTCHA immediately because she thought she had 24 hours and was waiting to have more updates of the resident 's health from the hospital.

The Director, under the LTCHA, was notified of the physical abuse the day after the incident through the Critical Incident System . Information pertaining to a physical abuse on a specified date in May 2016, was not reported immediately. [s. 24. (1)]

2. On a specified date in July 2016, at a specific time, resident #003 was found in co-resident #004's room, striking resident #004's body part with one hand and pinning down resident #004 other body parts with the other hand. Resident #004 told the staff member who discovered the incident that "the devil was sleeping in his/her bed, that he/she told resident #003 to get out of his/her bed, and then resident #003 got up and started pounding at him/her and couldn't get away". The physical altercation caused resident #004 to have redness and scratches with hand indentations to different part of the body.

During an interview with the infection control/occupational health and safety coordinator who was the manager on call at the time of the incident, she told Inspector #592 that she was not made aware of the physical abuse until the next morning when she listened to her voicemail messages. The voicemail was left by the RN who worked the night shift after the incident and was not present at the time of the incident. The Coordinator further told Inspector #592 that the Registered nurse on duty did not reach her at the time of the incident and that she should of report immediately the incident of abuse to the Director. However this was not done until the next morning. [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 a person who as reasonable grounds to suspect that abuse has occurred, immediately report the suspicion to the Director, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #003 and resident #004 by not implementing the identified interventions. (log #019871-16)

A review of Resident #003's health care records indicated that resident #003 was admitted on a specified month in 2014 with several diagnoses with cognitive impairment and other medical issues.

A critical Incident was send to the Ministry of Health and Long Term Care relating to resident #003 alleged abuse with resident #004.

A review of the resident #003's progress notes indicated that on a specified date in July 2016, at a specific time, resident #003 was found in co-resident #004's room, striking resident #004's specific body part with one hand and pinning down resident #004's other body parts with the other hand. Resident #004 told the staff member who discovered the incident that "the devil was sleeping in his/her bed, that he/she told him/her to get out of his/her bed, and then he/she got up and started pounding at him/her and couldn't get away". The physical altercation caused resident #004 to have redness and scratches with hand indentations to different part of the body.

Review of resident #003's current plan of care identified resident #003 with a history and episodes of anger, aggression and agitation towards staff and co-residents especially during the presence of a urinary tract infection, pain or altered mood. The interventions

included to monitor and document behaviour and obtain recommendations by the Tri-County Mental Health Services who have been involved with the resident since the summer of 2015. The interventions also included to monitor the resident to ensure safety when agitated and offer support to redirect and attempt to calm him/her. As well, the staff are to report observed aggression towards staff and other residents by monitoring resident #003 whereabouts and by using the Gentle Persuasive Approach techniques.

Upon a review of the resident #003's health Care Record, it was observed that on a specified date in May 2016 at a specific time, resident #002 was found on the floor outside of his/her bedroom in the hallway. Resident #002 was lying in supine position, shouting that a resident had pushed him/her down. Resident #002 told staff members that he/she was trying to get into his/her room but co-resident #003 would not allow him/her to, leading to an altercation between both residents, resulting in resident #003 pushing resident #002 causing him/her to fall. The fall resulted in a large contusion to the back of resident 002's skull and an injury to another specific body part. Resident #002 was immediately sent to the hospital where he/she was diagnosed with an injury of a specific body part.

The documentation further indicated that on a specific date in June 2016, at a specific time, staff heard screaming for help from hallway. When staff arrived, resident #003 was smiling and quietly pushing resident #004 in his/her wheelchair. Resident #003 was escorted away from resident #004 who told the staff that co-resident #003 had been hitting his/her in the head. Incident was unwitnessed and no injuries were noted at that time.

The documentation further indicated that on a specific date in June 2016, at a specific time, resident #003 was found lying in bed with resident #004. Resident #003 was redirected and resident #004 went back to sleep. Later on that day, resident #003 was found in resident #004's room starting striking him/her and staff entered the room and removed resident #003 from the area.

The documentation further indicated that another specified date in June 2016, resident #004 was sitting at the dining room table when resident #003 was brought in and he/she said repeatedly " you bringing that thing here" . Resident #004 was finished his/her breakfast and was moved out of the dining room.

Review of the Responsive Behaviours Management program of the home indicates that the purpose of the program is to act as a forum of advice and a sounding board for front

line staff when challenging resident behaviour incidents arise. It further indicates that each resident deserves an individualized plan of care utilizing a multidisciplinary approach that addresses any responsive behaviours exhibited.
Several tools were identified to use by the staff members such as:

The Dementia Observation System (DOS)
The Behaviour of concern
The Cohen-Mansfield Agitation Inventory

Upon a review of the resident #003's health care records between a specific day in May and July 2016, no behavioral tools were found.

During an interview with the Patient Resident Relation adviser in charge of the Responsive Behaviours Management disciplinary meeting, she told Inspector #592 that nursing members are present at the behaviour management meeting which are held on a monthly basis. She further told Inspector #592 that no specific tools were used, specific interventions, directions or plans were implemented following the altercation in May 2016 involving resident #003. She further told Inspector #592 that she thought that following the meeting, the nurses, the interventions would have been implemented as needed.

Upon a review of the physician orders for the month of June 2016, several changes in medications were done. However, it was documented that resident #003 refused her anti-depressant , antipsychotic and another anti-depressant several times.

During an interview with RPN #103, she told Inspector #592 that resident #003 wanders all the time and he/she is unpredictable. He/she is constantly seen by Tri-County Mental Health Services, the Nurse practitioner and the physician. She further told that medications were changed constantly, and resident continued to have altercation with co-residents whenever resident #003 wanted to use co-residents beds. She further told Inspector #592 that a specific medication was ordered as needed for extreme agitation. This medication was to be used when potential safety threat to herself or others. However, the medication was taking too long to be effective as the resident's behaviours occur suddenly. As well, she further told Inspector #592 that the resource person (BSO) was only on the floor on a specific day and was not only assigned specifically to resident #003, as they have other residents. Therefore the (BSO) was not used as a resource for the team. She further told Inspector #592 that often resident #003 was refusing his/her medications.

During an interview with RN #104 (resource person for the behaviour program), she told Inspector #592 that resident #003 wanders room by room. The psychogeriatric team was involved and tried several medications, but resident #003 still remained unpredictable with no specific target or triggers other than laying in other residents bed. She told Inspector #592 that the staffs are instructed to report to Registered staff every issues related to behaviours in order for Tri-County Mental Health Services to be made aware of residents status which are coming on a monthly basis to evaluate the residents. She further told Inspector #592 that no specific tools were used for the resident to identify specific patterns or triggers since resident was unpredictable. However, the tools would have been completed if requested by the physician or Tri-County Mental Health. RN told Inspector #592 that she does not know what to do anymore but continues to refer resident to the Tri-County Mental Health Team and document the effectiveness of the new interventions. RN #104 further told Inspector #592 that she was afraid of potential risk for other residents, since resident #003 is unpredictable and interventions remains ineffective.

During an interview with RPN #108 who was present on the specific date of the incident, she told Inspector #592 that resident #003 was unpredictable and that there was no specific interventions being put in place since that incident. The present interventions is to monitor residents whereabouts the best that they could and not seat resident #003 and #004 at the same table for meals. She further told Inspector #592 that usually the home will use a tool titled the "Dementia Observation System" (DOS) which are to be started when residents are exhibiting responsive behaviours and she would need to clarify with the DOC when to use the tool.

During an interview with the DOC, she told Inspector #592, that resident #003's triggerr was roaming. She further told Inspector #592 that resident #003 wants to lay down in any residents bed resulting in altercations with co-residents.
The interventions in place are to remove the resident from the area and continuing to follow the instructions from the home physician and the Tri-County Mental Health Team. She further told Inspector #592 that she would expect tools to be completed since there was new patterns on days and evenings of altercation and that she will have to reinforce with the staff when to use them. She also told Inspector #592 that she would expect any mood and behaviour patterns, including wandering into other co-residents bed which are potential behavioral triggers for resident #003 to be identified in the resident's plan of care.

Review of resident #003's care plan between April and July 2016 and the care plan did

not identify the steps required to minimize the risk of altercations and potentially harmful interactions between resident by not identifying and not implementing interventions related to resident #003 using co-residents beds.

On two specified dates, there was altercation and harmful interaction between resident #003 and #002. The monitoring of residents that was put in place at the time of the incident was not effective to prevent a second altercation from occurring again between resident #003 and resident #004. [s. 54. (b)]

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 steps will be taken to minimize the risk of altercation between resident #003 and other co-residents by implementing identified interventions, to be implemented voluntarily.

Issued on this 18th day of July, 2016

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

Original report signed by the inspector.