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

Division de la responsabilisation et de la performance du système de santé
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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
Feb 4, 2016	2015_395613_0022	032429-15, 017144-15, 021799-15	Critical Incident System

Licensee/Titulaire de permis

AUTUMNWOOD MATURE LIFESTYLE COMMUNITIES INC.
130 ELM STREET SUDBURY ON P3C 1T6

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

CEDARWOOD LODGE
860 GREAT NORTHERN ROAD SAULT STE. MARIE ON P6A 5K7

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

LISA MOORE (613)

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): December 14 - 18, 2015

A concurrent Complaint Inspection #2015_395613_0021 was also conducted during this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director/Director of Care (ED/DOC), Assistant Director of Care (ADOC), Director of Support Services (DOSS), RAI Coordinator, Scheduler, Maintenance, Recreation Aide, Registered Staff (RN/RPN's), Personal Support Workers (PSW's), Residents and Family members.

During the course of the inspection, the Inspector conducted a daily walk through of the resident home and various common areas, made direct observations of the delivery of care and services provided to the residents, observed staff to resident interactions, reviewed resident health care records and various policies and procedures of the home.

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

During the course of this inspection, Non-Compliances were issued.
- **7 WN(s)**
- **7 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that resident #006 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

On December 17, 2015, Inspector #613 reviewed a Critical Incident that was reported to the Director. The Critical Incident identified that resident #006 had a fall. In July 2015, resident #006 was heard yelling from their room. When staff entered the room, resident #006 was observed on the floor, sitting in a semi-fowler's position with legs tented (bent) and partially on their side. The resident was transferred to the hospital for further investigation due to a change in their health status. On the same day, the home was informed by the hospital that resident had sustained an injury. The resident returned to the home on the same date.

On December 17, 2015, the Inspector completed a health care record review on resident #006 and reviewed the most current care plan accessible to staff. The care plan identified that resident had a urinary intervention, a mechanical lift for transfers during the day and two person assist for all mobility. The Inspector observed resident and did not note an urinary intervention, resident transferred independently and was able to reposition self in their bed.

Inspector requested resident #006's care plan that was in place at the time of the incident and the updated care plan that was in place after the incident occurred. Interdisciplinary team member #109 provided the Inspector with resident #006's care plan that was in place post the incident. Interdisciplinary team member #109 reported that they could not provide the care plan that was in place prior to the incident as staff were shredding the old care plans and they were not saved on the computer. Interdisciplinary team member #109 reported that the updated care plan provided to the Inspector was not actually updated and did not contain accurate information. Interdisciplinary team member #109 reported that the care plan identified resident #006 to have urinary interventions however, this was not current. Interdisciplinary team member #109 confirmed that the care plan had not been updated to meet resident #006's current care needs.

On December 18, 2015, the Inspector met with RN #113 who confirmed that resident #006's care plan had not been updated since resident had sustained their injury. RN #113 stated the urinary interventions were discontinued shortly after the incident occurred in July 2015. [s. 6. (10) (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 by ensuring that resident #006 is reassessed and their plan of care reviewed and revised at least every six month and at any other time when resident #006's care needs change or the care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that they protected resident #004 from abuse by resident #003.

Inspector #613 reviewed a Critical Incident that was reported to the Director. The Critical Incident identified that resident #004 was abused by resident #003. The incident occurred on November 2015.

A late entry note, was documented in Mede-care, that the previous day, Manager #107 had notified resident #003's substitution decision maker, physician and the police of the abuse by resident #003 towards resident #004. As well on this date, RN #113 had documented in Mede-care enotes that resident #003 had thought resident #004 was their spouse and the writer had witnessed this previously, the care plan was updated to reflect this and to ensure resident #003 and resident #004 were not left alone together. RN #113 documented that they would alert all staff at shift change so they would continue to monitor. Dementia Observation System documentation commenced.

The critical incident form identified that the home's interventions following the abuse were resident #004 was moved to another table in the dining room. Resident #004 would be placed at their table in the dining room only when staff was present to supervise. Resident #003 was monitored every fifteen minutes for their whereabouts and was not to be left alone in any room with female residents. The critical incident report identified that resident #004's care plan required no updates as resident #004 allegedly had no effects from the incident due to their cognitive status.

The Inspector reviewed resident #003's care plan which identified that staff were to be sure of resident #003's whereabouts. There was no documentation to monitor every fifteen minutes. The care plan stated that resident #003 thought resident #004 was their spouse. Interventions were put in place to ensure resident #003 was separated from resident #004 and not to be left alone in a room with any female resident.

Inspector #613 reviewed Mede-care enotes documentation that identified resident #003 had two previous occurrences where they thought resident #004 was their spouse. During two incidents that occurred in June 2015 and July 2015, resident #003 displayed responsive behaviours towards other residents and visitors, regarding confusion over resident #004 being their spouse. No physically responsive behaviours occurred on these two previous occasions. The documentation demonstrated that the staff were aware that resident #003 thought resident #004 was their spouse since June 2015 and would watch and follow resident #004. Staff did not implement any interventions to protect resident #004 from resident #003 until after the incident of abuse occurred in November 2015. [s. 19. (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 by ensuring that resident #004 is protected from sexual abuse by resident #003 at all times, to be implemented voluntarily.

WN #3: 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 failed to ensure that the written policy in place to promote zero tolerance of abuse by resident #003 towards resident #004 was complied with.

The Inspector #613 reviewed a Critical Incident that was reported to the Director. The Critical Incident identified that resident #004 was abused by resident #003.

Inspector #613 reviewed the home's policy and procedure titled, 'Prevention of Abuse & Neglect of a Resident', policy #VII-G-10.00 with a current revision date of January 2015. The policy and procedure identified that the Charge Nurse was to document the current resident status on the resident's record and complete a Critical Incident Report. The policy also identified the Executive Director/Administrator or designate initiates the investigation by requesting that anyone aware of or involved in the situation write, sign and date a statement accurately describing the event, reiterating anonymity and protection against retaliation. All investigative information is kept in a separate report from the resident's record. An Inter-professional Team Debriefing meeting must be arranged as soon as feasible to and revise resident care plan as needed.

On December 16, 2015, the Inspector met with the Executive Director/Director of Care (ED/DOC) to request the investigation report that had been conducted by the home. The ED/EDOC was unable to provide the investigation report to the Inspector as they were unable to locate it. On the same date, the Inspector met with Manager #107 to inquire about the internal investigation report. Manager #107 informed the Inspector that there was no investigation report.

The home did not follow their policy and procedure for staff's responsibilities and interventions immediately as outlined. There was no evidence that the charge nurse had documented resident #004's current status on the resident's record. There was no evidence that the Executive Director/Administrator or designate initiated the investigation by requesting that anyone aware of or involved in the situation write, sign and date a statement accurately describing the event, reiterating anonymity and protection against retaliation. There was no separate report form the resident record containing the investigation information. As per the home's policy, all investigative information was to be kept in a separate report from the resident's record. There were no Inter-professional Team Debriefing meeting minutes for the Inspector to review to identify that the resident #003's care plan had been revised. [s. 20. (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 by ensuring that a written policy to promote zero tolerance of abuse and neglect of residents and to ensure that the policy is complied with, to be implemented voluntarily.

WN #4: 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 failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that the licensee knows of or that is reported to the licensee is immediately investigated.

The Inspector #613 reviewed a Critical Incident that was reported to the Director. The Critical Incident identified that resident #004 was abused by resident #003.

On December 16, 2015, the Inspector met with the Executive Director/Director of Care (ED/DOC) to request the investigation report that had been conducted by the home. The ED/EDOC was unable to provide the investigation report to the Inspector as they were unable to locate it. On the same date, the Inspector met with Manager #107 to inquire about the internal investigation report. Manager #107 informed the Inspector that there was no investigation report.

The licensee was unable to provide documentation to identify that they had investigated the abuse occurrence in November 2015 by resident #003 towards resident #004. [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 by ensuring that every alleged, suspected or witnessed incident of a resident by anyone that the licensee knows of or that is reported to the licensee is immediately investigated, to be implemented voluntarily.

WN #5: 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 the Director was informed immediately of the abuse of a resident #004 by resident #003 that resulted in harm or a risk of harm to the resident.

On December 16, 2015, Inspector #613 reviewed a Critical Incident that was reported to the Director. The Critical Incident identified that resident #004 was abused by resident #003.

The incident occurred in November 2015. The Critical Incident was submitted to the Director the next day.

On December 16, 2015, Inspector met with Manager #107 who reported that resident #004 had no effects from the incident.

On December 17, 2015, Inspector met with the Executive Director/Director of Care (ED/EDOC) who was not in their current position at the time of the incident but confirmed that the Critical Incident was submitted late to the Director. [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 by ensuring the Director is informed immediately of the abuse of any resident that resulted in harm or risk of harm to the resident, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when residents' #001 and #006 had fallen, the residents were assessed and that when the condition or circumstance of the residents required a post fall assessment, it was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

On December 16, 2015, Inspector reviewed an internal incident report that was not required to be submitted to the Director. The incident report identified that resident #001 had a fall in November 2015. The incident did not result in any injury to resident #001.

On December 17, 2015, Inspector reviewed a Critical Incident that was reported to the Director. The Critical Incident identified that resident #006 had a fall. In July 2015, resident #006 was heard yelling from their room. When staff entered the room, resident #006 was observed on the floor, sitting in a semi-fowler's position with legs tented (bent) and partially on their side. The resident was transferred to the hospital for further investigation due to a change in their health status. On the same day, the home was informed by the hospital that resident had sustained an injury. The resident returned to the home on the same date.

Inspector #613 reviewed #001's and #006's incident reports regarding the falls, documentation in Mede-care and documentation in the resident's health care records (paper records). The Inspector was unable to locate Post Fall Assessments for both resident #001 and #006's falls. The Inspector reviewed the home's Falls Prevention Policy (VII-G-30.00)with a revision date of January 2015. The policy stated that registered staff would complete an electronic post fall assessment by using the Post Fall Huddle or Fall Incident Report.

Inspector #613 interviewed Manager #107 to inquire if the home used a post fall assessment. Manager #107 confirmed that the post fall assessments were not completed by staff for either resident #001 or #006's falls. The Manager reported that staff were unaware they had to complete the post fall assessments post a resident fall. Manager #107 reported that they were unaware the registered staff were not completing the post fall assessments. [s. 49. (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 by ensuring a post fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was informed no later than one business day after the occurrence of an incident that caused an injury to a resident that resulted in a significant change in the resident #006's health condition and for which the resident was taken to the hospital.

On December 17, 2015, Inspector #613 reviewed a Critical Incident was reported to the Director. The Critical Incident identified that resident #006 had a fall. In July 2015, resident #006 was heard yelling from their room. When staff entered the room, resident #006 was observed on the floor, sitting in a semi-fowler's position with legs tented (bent) and partially on their side. The resident was transferred to the hospital for further investigation due to a change in their health status. On the same day, the home was informed by the hospital that resident had sustained an injury. The resident returned to the home on the same date.

The Critical Incident was submitted to the Director two business days after the fall occurred.

On December 17, 2015, Inspector met with the Executive Director/Director of Care (ED/EDOC) who was not in their current position at the time of the incident but confirmed the Critical Incident was submitted late to the Director. [s. 107. (3) 4.]

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 by ensuring the Director is informed no later than one business day after the occurrence of an incident that caused an injury to a resident that resulted in a significant change in the resident's health condition and for which the resident was taken to the hospital, to be implemented voluntarily.

Issued on this 10th day of February, 2016

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

Original report signed by the inspector.