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
Jun 9, 2015	2015_289550_0009	O-001935-15	Resident Quality Inspection

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 BOURGET
2279 Laval Street P.O. Box 99 Bourget ON K0A 1E0

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

JOANNE HENRIE (550), LINDA HARKINS (126), LISA KLUKE (547)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): April 27, 28, 29, 30 and May 1, 4, 5, 6, 7 and 8, 2015

Logs #O-001447-14 and #O-008651-15 were also completed during this inspection.

During the course of the inspection, the inspector(s) spoke with The Administrator (ADM), the Regional Manager, the Director of Nursing (DON), the Activity Director, the Environmental Manager (EM), the RAI Coordinator, the Administrative Assistant, the Nursing Staff Coordinator, the President of the Family Council, several Registered Staff, several Personal Support Workers, several Residents and several Family Members. The inspectors also reviewed policies and procedures, audits, residents health records, an anonymous complaint, minutes of the Resident Council and minutes of the Family Council.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Recreation and Social Activities
Residents' Council
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing
Trust Accounts

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

10 WN(s)
2 VPC(s)
2 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 O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The Licensee has failed to ensure that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the Licensee shall ensure that procedures are developed and implemented for,

(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and, if there are none, in accordance with prevailing practices:

(ii) Supplies and devices, including personal assistance services devices, assistive aids and positioning aids.

Inspector #550 observed Resident #004's wheelchair frame, padding and straps on each side of the chair and bean bag under the seat were visibly dirty with dried food/liquids on April 29, May 4 and 5, 2015.

PSW staff #S102 indicated to Inspector #550 resident's ambulation equipment is cleaned two times per week by the night PSWs. Inspector # 550 reviewed the "Caressant Care Bourget Night Cleaning Schedule" form and observed that Resident #004's wheelchair is scheduled to be cleaned on Monday and Thursday night. Procedure is documented as follow:

-All equipment is to be cleaned with R2 soap and dried and put back in resident room.
-Razors are to be cleaned with alcohol and put back in resident rooms.
-Tidy up resident rooms and common areas.

PSW staff #S107 indicated to Inspector #550 it is the responsibility of the night PSWs to do a thorough cleaning of the resident's mobility equipment twice a week as per the established schedule. She indicated she wiped down Resident #004's wheelchair seat, back and head rest this morning but does not do the other parts of the wheelchair as it is done twice per week by the night PSWs. She indicated if any spills occur, she will wipe them.

Inspector #550 accompanied with the Director of Care observed Resident #004's wheelchair seat, frame, nylon straps and bean bag under the seat to be visibly soiled with dried food/liquid. The DOC indicated Resident #004's wheelchair was scheduled to be cleaned the night before and it was not cleaned. She indicated she does audits to ensure the cleaning schedule is being followed and it is expected of all PSWs to wipe any spills on ambulation equipment as they occur. She further indicated this is a big issue amongst all PSWs as they will say it is not their responsibility to do so; it is the responsibility of the night PSWs to clean ambulation equipment.

On April 28, 2015 Inspector #126 observed Resident #005's shoulder harness positioning aid to be visibly dirty with dried pureed food.

The Director of Care indicated to Inspector #126 that night staff are to clean the resident equipment such as the wheelchair and the belt on a weekly basis. On May 5, 2015, Inspector #126 and the DOC observed that Resident #005's four point trunk restraint was visibly soiled with dried pureed food and should have been cleaned on Tuesday and Friday as per the schedule. [s. 87. (2) (b)]

2. The licensee failed to ensure that lingering offensive odours are addressed in resident home areas on the 1st floor, including common areas, hallways and residents shared bathrooms and rooms, despite routine cleaning.

The licensee has a history of non-compliance related to lingering offensive odors. Compliance Order #002 was issued on December 22, 2014 as a result of inspection #2014_200148_0044 with a compliance date of March 31, 2015.

Prior to this, there has been non-compliance issued to the home on the following dates:
-September 5, 2014 a Voluntary Plan of Correction was issued as a result of inspection #2014_198117_0023
-February 26, 2013 a Voluntary Plan of Correction was issued as a result of inspection #2013_193150_0002
-August 28th, 2012 a Voluntary Plan of Correction was issued as a result of inspection # 2012_054133_0035.

On April 27, 28, 29, 30, May 1, 4 and 5, 2015 Inspectors #550, #547 and #126 observed a lingering odor of urine upon entrance of the home on the first floor main entrance area and in the hallway on the first floor leading to rooms 1 and 2 at various times during the day. On May 5, 2015 at approximately 10:00am, Inspectors #550 and #117 observed a strong urine odor in the shared bathroom in room 1 and in the room and bathroom in room 2.

Inspector #550 interviewed both the Administrator and the Environmental Supervisor on May 1st 2015 at 1:30pm. They indicated to Inspector #550 since the Compliance Order was issued in December 2014, the Environmental Supervisor has implemented daily audits that he does himself on weekdays. This audit consists of a daily odor control walk through throughout the home and he immediately corrects any offensive odors. The Environmental Supervisor indicated to inspector he has revised the housekeeping staff routine to have the 5 specified rooms with odor issues be cleaned first thing in the morning; they have replaced all raised toilet seats, changed the floor cleaner to Stride Neutral floor cleaner by Johnston Diversy and are now using Virex 256 to clean all toilets and sinks. Housekeeping staff now have only two cleaning/disinfectant cleaner; one for the floor and another for all the rest. He installed battery operated air fresheners in some of the resident's washrooms to mask the odors. He further indicated to Inspector #550 the resident in room 2 did not like the smell of urine and used to place a fan in his/her bedroom window to blow fresh air in the room but this was also blowing the urine smell in the hallway. This fan was removed. The Environmental Supervisor instructed staff to remove the resident's bed sheets first thing in the morning as he/she is always incontinent at night and he placed a closed hamper in this room to contain the soiled sheets until they are sent to the laundry.

During a tour of rooms 1 and 2 with Inspector #550, the Administrator and the Environmental Supervisor observed the lingering urine odor in the shared bedroom and washroom in room 1 and in bedroom and washroom in room 2. The washroom in room 1 was clean including the floor, toilet and the caulking around the toilet was new at the time of this observation. The Environmental Supervisor indicated the batteries for the air freshener in the shared washroom in room 1 possibly needed to be replaced. The bedroom and washroom in room 2 was also clean at the time of the observation. Inspector #550 discussed with the Administrator and the ES that this odor issue is persistent; it has been identified many times in the past and it still is not resolved. The Administrator indicated he may need to look at replacing the tiles in the washroom in room 1.

Inspector #550 reviewed the home's "daily odor control walk through" forms from April 1st to May 1st, 2015. It was documented:
-on April 02, 2015, in the 2nd floor shower room there was a smell in the room due to soiled linen.
-on April 9th, 2015 it was documented there was a smell in a specific room due to soiled linen on the floor.
- April 28th, 2015 it was documented there was urine on floor in a specific room , soiled blanket on chair in another specific room and soiled hamper in lounge 1st floor
- May 1st, 2015 it is documented floor needs scrubbing in a specific room and linen hamper missing in another specific room.
No other documentation was observed.

Inspector #550 reviewed the home's ''Odor Control'' policy, with a review date of April 2015 and observed there is no procedures to address persistent lingering offensive odors. [s. 87. (2) (d)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times except as provided for in the regulations.

The home is a 56 beds long term care facility. During the Resident Quality Inspection, Inspector #550 reviewed the home's registered nursing staff schedule from February 15 to May 9, 2015 and observed that during this period, there was no Registered Nurse on duty and present in the home for the following shifts:

March 17 - day shift
March 18 - night shift
March 21 - day shift
March 29 - night shift
April 1 - evening shift
April 5 - evening shift
April 15 - night shift
April 17 - day shift
April 19 - day shift
April 22 - night shift

During an interview, both the Director of Care and the Administrator indicated to Inspector #550 there was no Registered Nurse on duty or present in the home for all of the above shifts and that all shifts were covered by Registered Practical Nurses. The Director of Care indicated that when a RN calls to be replaced, the home will offer the shift to all available Registered Nurses on their recall list and offer overtime to the scheduled Registered Nurses. When there are no Registered Nurses available to cover the shift, they will offer the shift to their Registered Practical Nurses as per their recall list.

Under O. Reg 79/10, s. 45. (2) an "emergency" means an unforeseen situation of a serious nature that prevents a Registered Nurse from getting to the long-term care home. The Administrator indicated to Inspector #550 that for all the above shifts, none were absences related to an emergency situation.

As such, the home did not ensure that there was a Registered Nurse on site in the home at all times. [s. 8. (3)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices for zone 7 with three out of forty beds observed during this inspection.

The "Adult Hospital Beds: Patient Entrapment Side Rail Latching Reliability, and Other Hazards", Health Canada Guidance Document indicates:
"Zone 7 is the space between the inside surface of the head board or foot board and the end of the mattress. This space may present a risk of head entrapment when taking into account the mattress compressibility, any shift of the mattress, and degree of play from loosened head or foot boards".

On April 28, 2015, Inspector #550 noted a four inch gap between the foot board and the mattress for the resident in room 1 bed 1.
On April 28, 2015, Inspector #547 noted a six and a half inch gap between the foot board and the mattress for the resident in room 201 bed 4 and a five inch gap between the foot board and the mattress for the resident in room 205 bed 1.

On May 1, 2015, the Environmental Manager indicated to Inspector #547 that he had completed the Facility Entrapment Inspection from December 2014 to February 2015. He indicated he had received training on how to perform this inspection and then documented his findings on a Facility Entrapment Inspection Sheet. On May 5, 2015 The Environmental Services Manager demonstrated to Inspector #547 how he tested for Zone 7 with room 1 bed 1 and 205 bed 1 and indicated that these bed mattresses and frames today would have failed. he further indicated that he did not put the head of the bed down or had pushed the mattress up to the top of these beds to perform the inspection of zone 7 as required.

On May 5, 2015 Inspector #547 interviewed the Regional Manager for Caressant Care who was the acting Administrator for that day. She indicated that the Environmental Services Manager did receive the training provided regarding bed entrapment assessment, but he possibly did not follow the procedure for zone 7. A follow-up training was arranged for the following day with the same company who originally provided the training to review the bed inspection training and procedures to follow. [s. 15. (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 proper evaluations are conducted on all resident's bed to minimize the risk of entrapment, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff monitor and record symptoms of infection in residents on every shift and that immediate action is taken as required.

It is documented in the progress notes on April 14, 2015, that Resident #026 had vomiting and two episodes of diarrhea and that Resident #027 had a loose stool.

It is documented in the progress notes of April 15, 2015, that Resident # 007 was administered Gravol 50 mg Suppository at 22:55 by Registered Nursing Staff S#108. No reason for the administration of the antiemetic is documented.

It is documented by Registered Nursing Staff S#108, on the Facility Bulletin Board Report dated April 15, 2015 that Resident # 007 is on enteric (precautionary) isolation.

The home's policy "Infection Prevention & Control Co-ordinator" dated November 2012 indicated under responsibilities: 3. "Ensure that daily monitoring to detect, record and manage the presence of infections in the home occurs.

On May 7, 2015, the Director of Care (Infection Control Lead), indicated to Inspector #126 that staff are to complete daily monitoring summary of infections sheet by documenting signs and symptoms of infections on this sheet. Inspector #126 interviewed two Registered Nursing Staff and one Registered Practical Nursing staff regarding daily monitoring of symptoms of infections. They were aware they were to complete the Public Health Unit (PHU) line listing form when the home is experiencing an outbreak but never indicated the utilization of the daily monitoring summary of infections sheet.

The daily monitoring sheet for the first floor was reviewed for the month of April 2015 by Inspector #126 and no documentation was found related to the residents presenting enteric symptoms on April 14 and 15, 2015.

An enteric outbreak was declared on April 16, 2015 with 7 residents on the first floor who experienced enteric symptoms during the night, 5 other residents on the first floor that experienced symptoms during the day and 2 staff who experienced symptoms on that same day.

The nursing staff did not monitor and record symptoms of infections of residents on every shift and did not ensure that immediate action was taken as required. [s. 229. (5)]

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 symptoms of infection in residents are monitored on every shift, recorded and that immediate action is taken, to be implemented voluntarily.

WN #5: 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 a written plan of care set out clear direction to staff and others who provide direct care to the resident.

On April 28, 2015 during the resident interview, Resident #008 indicated to Inspector #126, that he/she has no paper towel in the bathroom to dry his/her hands. Resident #008 is in a ward room with 4 residents which he/she is the only one using the bathroom independently.

On May 8, 2015, discussion held with Personal Support Worker (PSW) S#102 and Housekeeping Staff S#113, indicated that Resident #008 unrolled the paper towel in the bathroom and almost blocked the toilet on a few occasions. The intervention in place to minimize this behavior is to give Resident #008 a cloth hand towel to dry his/her hands.

On May 8, 2015, discussion held with the Director of Care , she indicated that she was aware that Resident #008 had one episode with paper towel, but she was not aware that it happened more than one time. Discussion held with evening RPN S#115, she indicated that she was not aware of Resident #008's behavior with paper towel. She indicated that she would update the plan of care to reflect Resident #008's behavior with paper towel, to give clear directions to staff and to ensure Resident #008 does have a cloth hand towel at all times to dry his/her hands. [s. 6. (1) (c)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 12. Furnishings

Specifically failed to comply with the following:

s. 12. (2)The licensee shall ensure that,
(a) resident beds have a firm, comfortable mattress that is at least 10.16 centimetres thick unless contraindicated as set out in the resident's plan of care; O. Reg. 79/10, s. 12 (2).
(b) resident beds are capable of being elevated at the head and have a headboard and a footboard; O. Reg. 79/10, s. 12 (2).
(c) roll-away beds, day beds, double deck beds, or cots are not used as sleeping accommodation for a resident, except in an emergency; O. Reg. 79/10, s. 12 (2).
(d) a bedside table is provided for every resident; O. Reg. 79/10, s. 12 (2).
(e) a comfortable easy chair is provided for every resident in the resident's bedroom, or that a resident who wishes to provide their own comfortable easy chair is accommodated in doing so; and O. Reg. 79/10, s. 12 (2).
(f) a clothes closet is provided for every resident in the resident's bedroom. O. Reg. 79/10, s. 12 (2).

Findings/Faits saillants :

1. The Licensee has failed to ensure that a comfortable easy chair is provided for every resident in the resident's bedroom, or that a resident who wishes to provide their own comfortable easy chair is accommodated in doing so.

On April 28, 29, 30, May 1 and 4, 2015, Inspector #550 observed Resident # 016, #017 and Inspector #547 observed Residents #014, #018, #019, #020 and #021 did not have an easy chair in their bedroom.

During an interview, Resident #14 indicated to Inspector #550 he/she would like to have a chair in his/her room that he/she could sit on rather than lay on his/her bed all the time. Resident #021 indicated to Inspector #550 he/she would appreciate having a chair in his/her room. The indicated last week-end he/she had visitors and they had nowhere to sit; they sat on the bed and the resident ended up sitting on his/her walker. Resident #019 indicated to Inspector #550 he/she would like to have a chair in his/her room to sit on; he/she now sits on his/her walker but it is not very comfortable.

During an interview, PSW staff #S101 indicated to Inspector #550 Resident #016 does not have an easy chair in his/her bedroom, he/she always uses Resident #001's rocking chair when Resident #001 is not using it.

PSW staff S117 indicated to Inspector #550 Resident #020 would benefit from having an easy chair in his/her room as the resident often watches TV in his/her room.

During an interview, the Director of Care indicated to Inspector #550 she does not know why these residents do not have an easy chair in their room and she does not recall any reason that they should not have one. She indicated the home does provide easy chairs to residents as part of the room's furnishings. [s. 12. (2)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).**

Findings/Faits saillants :

1. The licensee has failed to ensure that the dining and snack service includes a review of the meal and snack times by the Residents' Council.

Inspector #550 interviewed the Director of Activities who is the Residents' Council assistant appointed by the home, she indicated to Inspector #550 the meal and snack times were not reviewed by the Council since she became the Director of Activities in December 2014.

During an interview, the Administrator indicated to Inspector #550 that upon a review of the Residents' Council's minutes of the past year, he was unable to find any documentation that the meal and snack times were reviewed by the Residents' Council. [s. 73. (1) 2.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

**s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents; O. Reg. 79/10, s. 89 (1).**

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of laundry services under clause 15(1)(b) of the Act, every licensee of a Long-Term care home shall ensure that a sufficient supply of clean face cloths are always available in the home for use by residents.

On May 4, 2015, Inspector #547 interviewed Staff S#101 regarding the lack of oral hygiene provided to Resident R#010 after the morning collation as there were no face cloths available for care of residents at that time.

On May 8, 2015 at 10:18am, Inspector #547 heard staff on the first floor discussing the lack of face cloths in the home for morning care for the residents. Inspector #547 then heard staff on the second floor of the home at 10:40 indicate that they also did not have any face cloths for resident care. On this same date, Inspector #547 interviewed the Environmental Services Manager who indicated that there should always be face cloths available to staff and residents. Inspector #547 observed both linen carts, and closets on the first and second floor and noted that no face cloths were present at this time.

The Environmental Services Manager indicated that he was not aware of any shortage of face cloths, as he places an order for face cloths at the beginning of each month. Staff S#103, S#102, S#112 indicated to Inspector #547 that the home has had a shortage of face cloths for the last few months, but that they are aware that an order was placed for the home yesterday to obtain face cloths.

Staff S#114 indicated that she was called in today as the home received a sick call, and was late with the linen. Upon review of the amount of face cloths provided to both first floor and second floor, it was noted that the home had a low supply of face cloths. Staff S#114 indicated that they do not audit or count the number of face cloths washed in the home, however is aware that there is not enough.

The Environmental Services Manager indicated that he ordered face cloths in February 2015, and again at the beginning of May 2015 as he did not place a face cloth order for March or April. The Environmental Services Manager indicated that he will begin an audit process to ensure that there is a sufficient supply of linen supplies available for resident care, and that he will order supplies as required monthly to prevent this shortage from happening again. [s. 89. (1) (b)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart, that is secure and locked.

On May 1st, 2015, Inspector #547 observed the first floor medication cart located outside resident room #11 and Resident #023 was stopped in front of the medication cart looking at the cart. Once this resident left the medication cart, it was noted that this cart was not locked. Inspector #547 remained beside this unattended medication cart, while Residents R#024 and R#025 went past this med cart. Resident R#023 came back by this cart once again during this ten minute period. Staff S#105 returned to the medication cart, and locked it immediately indicating that her medication cart should have been locked while she was away from it.

On May 6, 2015, Inspector #547 observed the medication cart on the second floor located next to the nursing station by the medication room, and this cart was not locked or attended by any Registered Nursing staff member at this time. Staff S#104 was in the dining room, out of eye sight for this medication cart. This medication cart was located in the main resident care hallway. Staff S#104 indicated that the home's expectation is that the medication cart should be kept locked when unattended.

On May 6, 2015, Inspector #547 was informed by Staff S#107 that two residents in the home had prescribed oral rinse and that the bottles were located at the resident bedsides. Inspector #547 observed the following:
- Resident #004 had a bottle of a specific oral rinse to use as directed, ordered on a specific date in 2014 that was in the residents bedside wash basin inside the top drawer of his/her dresser which was not locked and that was accessible to anyone in this shared bedroom.
- Resident #010 had a bottle of a specific oral rinse that was opened and located inside a wash basin inside the top drawer of the dresser that was not locked. Resident was ordered this rinse on a specific date in 2015 and is required to receive twice daily.

On May 6, 2015, Inspector #547 interviewed the Director of Care who indicated that the medication carts should always be locked when unattended, and prescribed oral rinse for residents were to be kept locked in the medication carts or the medication rooms as they are never to be left at the resident's bedside. [s. 129. (1) (a)]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (3) Subject to subsections (4) and (5), the licensee shall ensure that no person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse. O. Reg. 79/10, s. 131 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that person administers a drug to a resident in the home unless that person is a physician, dentist, registered nurse or a registered practical nurse.

On May 6, 2015, PSW staff #S110 indicated to Inspector #547 she had applied a specific mix of creams to Resident #022 to a specific body part and another specific type of cream to a specific body part. Inspector #547 reviewed the resident's health care records, and the physicians' orders indicated a specific mix of creams for 10 days to a specific body part and another specific type of cream to another specific body part. Review of the MAR sheet, to indicate that this cream was not applied on a daily basis from the 29th of April, 2015. Staff S#102 and S#107 indicated that they have applied this cream to the resident's specific body part. Staff S#107 further indicated that two residents in the home also receive a prescription oral rinse, that is left at the resident's bedside, that they are expected to use for mouth care for both residents, and do not have any area to document this in point of care.

On May 6, 2015, Inspector #547 interviewed the Director of Care, who indicated that prescribed creams and oral rinses are to be administered by the registered nursing staff, as they are to be signed for in the medication administration record for these residents once administered. The Director of Care indicated the Non-Registered nursing staff have not received any formal training from the home to apply medicated creams or medicated oral rinses. [s. 131. (3)]

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

Issued on this 10th day of June, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JOANNE HENRIE (550), LINDA HARKINS (126), LISA KLUKE (547)
Inspection No. / No de l'inspection :	2015_289550_0009
Log No. / Registre no:	O-001935-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jun 9, 2015
Licensee / Titulaire de permis :	CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED 264 NORWICH AVENUE, WOODSTOCK, ON, N4S-3V9
LTC Home / Foyer de SLD :	CARESSANT CARE BOURGET 2279 Laval Street, P.O. Box 99, Bourget, ON, K0A-1E0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Steve Golden

To CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2014_200148_0044, CO #002;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,

(a) cleaning of the home, including,

(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and

(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and

(iii) contact surfaces;

(c) removal and safe disposal of dry and wet garbage; and

(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Order / Ordre :

The Licensee shall ensure that procedures are developed and implemented to immediately address incidents of persistent lingering offensive odors, in 2 specific resident rooms and,

the home shall have a monitoring process in place to ensure that the procedures implemented to address the incidents of lingering offensive odors are effective.

Grounds / Motifs :

1. The licensee failed to ensure that lingering offensive odours are addressed in

resident home areas on the 1st floor, including common areas, hallways and residents shared bathrooms and rooms, despite routine cleaning.

The licensee has a history of non-compliance related to lingering offensive odors. Compliance Order #002 was issued on December 22, 2014 as a result of inspection #2014_200148_0044 with a compliance date of March 31, 2015.

Prior to this, there has been non-compliance issued to the home on the following dates:
-September 5, 2014 a Voluntary Plan of Correction was issued as a result of inspection #2014_198117_0023
-February 26, 2013 a Voluntary Plan of Correction was issued as a result of inspection #2013_193150_0002
-August 28th, 2012 a Voluntary Plan of Correction was issued as a result of inspection # 2012_054133_0035.

On April 27, 28, 29, 30, May 1, 4 and 5, 2015 Inspectors #550, #547 and #126 observed a lingering odor of urine upon entrance of the home on the first floor main entrance area and in the hallway on the first floor leading to rooms 1 and 2 at various times during the day. On May 5, 2015 at approximately 10:00am, Inspectors #550 and #117 observed a strong urine odor in the shared bathroom of a specific resident room and in the room and bathroom of another specific room.

Inspector #550 interviewed both the Administrator and the Environmental Supervisor on May 1st 2015at 1:30pm. They indicated to Inspector #550 since the Compliance Order was issued in December 2014, the Environmental Supervisor has implemented daily audits that he does himself on weekdays. This audit consists of a daily odor control walk through throughout the home and he immediately corrects any offensive odors. The Environmental Supervisor indicated to inspector he has revised the housekeeping staff routine to have the 5 specific rooms with odor issues be cleaned first thing in the morning; they have replaced all raised toilet seats, changed the floor cleaner to Stride Neutral floor cleaner by Johnston Diversy and are now using Virex 256 to clean all toilets and sinks. Housekeeping staff now have only two cleaning/disinfectant cleaner; one for the floor and another for all the rest. He installed battery operated air fresheners in some of the resident's washrooms to mask the odors. He further indicated to Inspector #550 the resident in a specific room did not like the smell of urine and used to place a fan in his/her bedroom window to blow fresh air in

the room but this was also blowing the urine smell in the hallway. This fan was removed. The Environmental Supervisor instructed staff to remove the resident's bed sheets first thing in the morning as he/she is always incontinent at night and he/she placed a closed hamper in this room to contain the soiled sheets until they are sent to the laundry.

During a tour of 2 specific rooms with Inspector #550, the Administrator and the Environmental Supervisor observed the lingering urine odor in the shared bedroom and washroom in a specific room number and in bedroom and washroom of another specific room number. The washroom in a specific room was clean including the floor, toilet and the caulking around the toilet was new at the time of this observation. The Environmental Supervisor indicated the batteries for the air freshener in the shared washroom in a specific room possibly needed to be replaced. The bedroom and washroom in another specific room were also clean at the time of the observation. Inspector #550 discussed with the Administrator and the ES that this odor issue is persistent; it has been identified many times in the past and it still is not resolved. The Administrator indicated he may need to look at replacing the tiles in the washroom in a specific room number.

Inspector #550 reviewed the home's "daily odor control walk through" forms from April 1st to May 1st, 2015. It was documented:
-on April 02, 2015, in the 2nd floor shower room there was a smell in the room due to soiled linen.
-on April 9th 2015, it was documented there was a smell in a specific room due to soiled linen on the floor.
- April 28th 2015, it was documented there was urine on floor in room a specific room, soiled blanket on chair in another specific room and soiled hamper in lounge 1st floor
- May 1st 2015, it is documented floor needs scrubbing in a specific room and linen hamper missing in another specific room.
No other documentation was observed.

Inspector #550 reviewed the home's ''Odor Control'' policy, with a review date of April 2015 and observed there is no procedures to address persistent lingering offensive odors.
(550)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 04, 2015

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee shall prepare, submit and implement a plan with strategies in place for achieving compliance to meet the requirement that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

The plan shall include all recruiting and retention strategies.

The plan must be submitted via e-mail to joanne.henrie@ontario.ca on or before June 22, 2015.

Grounds / Motifs :

1. The licensee has failed to ensure that there is at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present at all times except as provided for in the regulations.

This home is a 56 beds long-term care home. Under O.Reg. 79/10, s. 45 (1), homes with a licensed bed capacity of 64 beds or fewer,

i. a registered nurse who works at the home pursuant to a contract or agreement between the nurse and the licensee and who is a member of the regular nursing staff may be used,
ii. in the case of an emergency where the back-up plan referred to in clause 31 (3) (d) of this Regulation fails to ensure that the requirement under subsection 8 (3) of the Act is met,

A. a registered nurse who works at the home pursuant to a contract or agreement between the licensee and an employment agency or other third party may be used if the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone, or

B. a registered practical nurse who is a member of the regular nursing staff may be used if the Director of Nursing and Personal Care or a registered nurse who is both an employee of the licensee and a member of the regular nursing staff is available by telephone.

Under O. Reg 79/10, s. 45. (2) an "emergency" means an unforeseen situation of a serious nature that prevents a Registered Nurse from getting to the long-term care home.

During the Resident Quality Inspection, Inspector #550 reviewed the home's registered nursing staff schedule from February 15 to May 9, 2015 and observed that during this period, there was no Registered Nurse on duty and present in the home for the following shifts:

March 17 - day shift
March 18 - night shift
March 21 - day shift
March 29 - night shift
April 1 - evening shift
April 5 - evening shift
April 15 - night shift
April 17 - day shift
April 19 - day shift
April 22 - night shift

During an interview, both the Director of Care and the Administrator indicated to Inspector #550 there was no Registered Nurse on duty or present in the home for all of the above shifts and that all shifts were covered by Registered Practical Nurses. The Director of Care indicated that when a RN calls to be replaced, the home will offer the shift to all available Registered Nurses on their recall list and offer overtime to the scheduled Registered Nurses. When there are no Registered Nurses available to cover the shift, they will offer the shift to their

Registered Practical Nurses as per their recall list.

The Administrator indicated to Inspector #550 that for all the above shifts, none were absences related to an emergency situation.

As such, the home did not ensure that there was a Registered Nurse on site in the home at all times. (550)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 22, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 9th day of June, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Joanne Henrie

Service Area Office /
Bureau régional de services : Ottawa Service Area Office