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
Dec 22, 2016	2016_291194_0034	028496-16	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 HARRISTON
24 LOUISE STREET P.O. BOX 520 HARRISTON ON N0G 1Z0

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

CHANTAL LAFRENIERE (194), SAMI JAROUR (570)

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): November 14, 15, 16, 17 and 18, 2016

During the course of the inspection, the inspector(s) spoke with Residents, Administrator, Director of Nursing (DON), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Food and Nutrition Manager (FNM), Environmental Services Manager (ESM), Registered Dietitian (RD), RAI co ordinator, Housekeeping staff, Activation Aide, Registered Physiotherapist (RPT) , Hairstylist, Family and Resident Council representatives.

The inspectors also conducted a tour of the building, observed meal service, staff to resident provision of care, medication administration and infection control practices. Review of the licensee's relevant policies and resident clinical health records were completed.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

9 WN(s)
6 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

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 has failed to ensure that the care set out in the plan of care for resident #004 related to wound care was provided to the resident as specified in the plan.

During an interview with inspector #194 resident #004 indicated that during the bath, an applied treatment had fallen off and had not been replaced. Review of the Treatment Administration Record (TAR) for an identified month for resident #004 indicated a treatment was to be applied. During an interview with inspector #194 , RN #112 indicated working on the identified shift that the treatment had fallen off but was not informed by PSW staff that the treatment required to be changed. Inspector #194 was informed by resident #004 at the end of the following day that the treatment was reapplied later in the day, by RN # 112.

When interviewed by inspector #194 on identified date, RN #112 indicated that the treatment was not replaced until later on the identified date, because she did not have time. [s. 6. (7)]

2. The licensee has failed to ensure that when the resident was reassessed and the plan of care reviewed and revised when the resident's care needs change.

Review of the progress notes on an identified date indicated that resident # 004 had been assessed with an alteration in skin integrity. During an interview PSWs #109 and #105 indicated that resident #004 had protective equipment for alteration of skin integrity while up in wheelchair and while in bed. During an interview with inspector #194, resident #004 indicated that staff applied protective equipment and frequently asked to elevate affected body part. The current written plan of care for resident #004 does not identify the altered skin integrity or the interventions as indicated by resident #004 or PSW's #109 and #115. [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 residents with wound care are reassessed and the plan of care is revised when the care needs change and that the care set out for resident #004 is provided as specified related to wound care, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure the home, furnishings and equipment are kept clean and sanitary.

On November 14, 2016, during the tour of the residents' care areas, the following was noted:
- Shower area located in the Tub room of B hallway: a build-up of blackish substance on grout between flooring tiles in the shower stall areas.
- Shower area located in the Tub room of A hallway: a build-up of blackish substance on grout between flooring tiles and wall tiles in the shower stall areas.

On November 17, 2016 interview with housekeeping staff #114 indicated the shower areas are cleaned and scrubbed once a week. Staff #114 indicated awareness of blackish stain/build up in shower areas in Hallways A and B and further indicated that the

black build up between tiles have been like that for the last six month although the shower areas were cleaned and scrubbed with bleach and other cleaning materials with no effect.

On November 18, 2016 during an interview with the Environmental Services Manager (ESM) and the Administrator, both indicated being aware of the build up of the black substance/blackish stain between wall tiles (with missing grout in some areas) and between floor tiles in the above identified shower areas. The ESM indicated that the cause of the black substance/black stain had to do with the water in this area known to be heavy with iron content and acknowledged that the shower areas did not look clean. Both Administrator and ESM indicated that the shower areas are cleaned by housekeeping staff once a week. Both the Administrator and ESM indicated it is an expectation that the home be kept clean and sanitary. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

On November 14 and 18, 2016 it was observed by inspector #194 that the commode chair in an identified resident shared bathroom, was unsteady and rusted.

During an interview with inspector #194 on November 18, 2016, PSW #119 clarified that resident #025 and #026 would have accessed the shared bathroom and used the identified commode chair.

Review of the plans of care for resident #025 and #026 were completed by inspector #194 and identify both residents as being at risk for falls.

The commode chair in the shared bathroom was noted to be unsteady and rusted. PSW #119 identified that resident #025 and #026 utilized the commode chair and plans of care for both resident identified a risk for falls. The identified commode chair presented a safety risk due to the unsafe condition and the poor state of repair. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that the shower areas are kept clean and sanitary as well as commodes maintained in a safe and good state of repair, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system be easily seen, accessed and used by residents, staff and visitors at all times.

During an interview with inspector #194, resident #002 indicated that he did not have access to the resident-staff communication and response system by the bed. Observation of the identified resident's shared bedroom verified that no cord was attached for access to the resident-staff communication response system for resident #002 at the bedside.

During an interview with inspector #194, PSW #110 indicated not being aware of the missing cord at resident #002's bedside. ESM was observed by inspector #194 repairing the resident-staff communication response system, later in the day . [s. 17. (1) (a)]

2. The licensee has failed to ensure that a resident staff communication and response system is available in every area accessible by residents.

On November 15, 2016, Inspector noted the Hair Salon located in the D Hallway, which was accessible to residents, did not have a resident-staff communication and response system installed.

On November 15, 2016, the hair stylist staff #120 working in the Hair Salon indicated to the inspector being aware that there was no call bell and that she would call for help in case of an emergency situation involving a resident. Staff #120 further indicated that occasionally family members could ask the Administrator to unlock the door and use the Hair Salon.

On November 18, 2016 during an interview, the Environmental Service Manager indicated to the inspector no awareness that the Hair Salon did not have a resident-staff communication and response system.

On November 17, 2016, Interview with Administrator indicated that she was aware that the hair salon did not have resident-staff communication and response system installed as the residents were not left alone in the hair salon. The Administrator however did indicate that the Hair Salon is used by one or two family members. [s. 17. (1) (e)]

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 the resident-staff communication and response system is easily seen and accessible to residents, staff and visitors at all time in the Hair Salon, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #004 exhibiting altered skin integrity, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Resident #004 was admitted to the home on an identified date and a head to toe assessment was completed by registered staff indicating that resident #004 had an alteration in skin integrity. Review of the bathing assessment completed by PSWs at the home indicated that "Red and/or Open areas" had been identified for resident #004 during a two month period. The documentation for resident #004 completed by the PSW providing the bathing indicated that the red and/or open areas were reported to the registered staff on two identified dates. RPN # 121 working on an identified date and RN #105 working on the other identified date were interviewed by the inspector neither registered staff could remember being informed by PSW staff of resident #004's red or open area. Review of the clinical health record was completed and there is no evidence of any wound assessment provided by registered nursing staff for the period of two consecutive months where an alteration in skin integrity had been identified by PSW staff. A registered staff assessment was completed two months after admission, with significant change in skin integrity and treatment identified on the Electronic Treatment Assessment Record (E-TAR) for resident #004. [s. 50. (2) (b) (i)]

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 residents with altered skin integrity, receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #5: 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,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures are developed and implemented for addressing incidents of lingering offensive odours.

During the inspection dates of November 14-18, 2016 a strong urine odour was noted in bathrooms attached to three identified rooms.

During an interview PSW #107 indicated that there was a urine odour in bathroom attached to identified room and indicated that a similar urine odour is noted in the bathroom attached to two other identified rooms. PSW #107 further indicated that the bathrooms were cleaned by housekeeping staff but the urine odour continues as there could be urine under the floor tiles.

During an interview housekeeping staff #114 indicated that the identified bathrooms are cleaned once a day. If there is a urine odour, once bathroom is cleaned, the bathroom is sprayed with Bio 7 a product for odour in bathrooms. Staff #114 confirmed urine odours in bathrooms of the two identified room's and indicated urine odour also noted in bathroom of another identified room . Staff #114 indicated to the inspector that Management (ESM and Administrator) were aware of the odours in bathroom and that they are looking into different types of flooring.

Interview with the Environmental Services Manager (ESM) indicated awareness of urine odours in the three identified bathrooms. Both the ESM and Administrator indicated that different products have been tried to address odours in bathrooms including (enzyme / bio 7) and housekeeping staff continue to clean those bathrooms. Both the Administrator and ESM indicated it is an expectation that the home be kept clean and sanitary. [s. 87. (2) (d)]

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 procedures are developed and implemented for addressing incidents of lingering offensive odours, to be implemented voluntarily.

WN #6: 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. (5) The licensee shall ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident. O. Reg. 79/10, s. 131 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident.

On an identified date during a room observation for resident #001 a full bottle of over the counter medication was found on resident #001's bedside table. During interview conducted on an identified date, RN #105 indicated that resident #001 did not have physician's orders to self administer any medications.

The medications was removed from the resident area when RN #105 was notified by inspector #194.

On an identified date an interview with resident #001 was conducted by inspector #194 to determine if the resident was taking the over the counter medication. During the interview on an identified date resident #001 indicated to inspector #194 taking the over the counter medication from time to time. Inspector #194 enquired if resident #001 had any other drugs at the bedside, resident #001 indicated that there maybe more in the bedside table. Resident #001 opened the bedside table drawers and another over the counter medication noted in the drawer, resident #001 indicated that from time to time being in need of this and would apply with the assistance of staff.

Review of the resident's clinical health record was completed by the inspector on an identified date and there was no physicians order for the resident to self administer either the over the counter medication. [s. 131. (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 by ensuring that no resident administers a drug to himself or herself unless the administration has been approved by the prescriber in consultation with the resident, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

As required under O. Reg 79/10 s. 48(1) Every licensee of a long term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home.
(2) A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

Review of the licensee's "Wound Assessment" policy dated July 2016 indicated:

All residents with skin and wound issues shall have these appropriately treated and assessed by the registered staff in conjunction with the wound care champion and managers in the home. Registered staff shall utilize the E-tar (electronic Treatment administration record) on point click care and the Pixalere wound assessment program to document and assess wound treatments and wound progress.

PROCEDURE:

when a resident presents with a skin or wound issue, registered staff shall assess the area and appropriately document on Pixalere. This assessment shall include at minimum the following:
-location of skin/wound issue
-type of wound/skin issue(stage of wound, rash, skin tear etc)
-presence of drainage including amount, color and odor
-description of wound bed and surrounding tissue

-presence of undermining and or tunnelling
-pain expressed of resident
-photos of wound areas shall be recorded at a minimum for all staged 3 or higher wounds. it is recommended that these photos be updated monthly

-registered staff shall enter the skin/wound treatment on the e-tar indicating the specific treatment, frequency of dressing application/changes, 3M products to be used etc.

Resident #021 has a history of skin alterations since admission to the home.

During interviews with inspector #194 on an identified date Registered staff RN #105 and RPN #113 indicated that resident #021 was non compliant with skin care strategies.

Resident #021's MDS assessment on identified date indicated an alteration in skin integrity. Review of resident #021'sTreatment Administration Record (TARS) for an identified period does not identify the specific treatment, frequency of dressing applications/changes or 3M products to be used as directed by the licensee's "Wound Assessment" policy.

During a telephone interview with DOC on an identified date it was indicated that resident #021 did not have any specific treatment directions noted on the "Pixalere" program or TAR as directed by the licensee's "wound assessment" policy. [s. 8. (1) (a),s. 8. (1) (b)]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident bedroom occupied by more than one resident have sufficient privacy curtains to provide privacy.

During the inspection it was noted that privacy curtains were missing in an identified semi private room. The privacy curtains at the end of the bed for both residents in the identified room were missing. Resident #004 indicated to inspector that the privacy curtains had been torn and taken down approximately a month ago and had not been replaced. [s. 13.]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 14. Every licensee of a long-term care home shall ensure that every resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall. O. Reg. 79/10, s. 14.

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident shower has at least two easily accessible grab bars, with at least one grab bar being located on the same wall as the faucet and at least one grab bar being located on an adjacent wall.

On November 14, 2016, during the tour of the residents' care areas, the following was observed regarding grab bars in shower areas:
-a grab bar was not located on the adjacent wall of the faucet in the shower area located in the Tub room of B hallway.
- a grab bar was not located on the same wall as the faucet in the shower area located in the Tub room of A hallway.

On November 18, 2016 during an interview with Environmental Services Manager (ESM) and the Administrator, both indicated to the inspector that the shower areas identified above are being used by residents. The ESM indicated to the inspector no awareness that two grab bars are required in the shower area; the Administrator indicated awareness that two grab bars are required in the shower area but was not aware that a grab bar is to be located on the same wall as the faucet and at least on grab bar being located on an adjacent wall. [s. 14.]

Issued on this 22nd day of December, 2016

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

Original report signed by the inspector.