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 prévue le Loi de 2007 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
Direction de l'amélioration de la performance et de la conformité

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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Oct 30, 2015;	2015_355588_0015 (A1)	010393-15	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 ON MARY BUCKE
4 MARY BUCKE STREET ST. THOMAS ON N5R 5J6

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

Ontario

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Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

CHRISTINE MCCARTHY (588) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Inspection Log #010393-15, Inspection #2015_355588_0015 (A1), Compliance Order #001, s.153.(1)(a), with an original compliance date of November 1, 2015, amended to December 27, 2015.

Issued on this 12 day of January 2016 (A1)

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

Original report signed by the inspector.

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CHRISTINE MCCARTHY (588) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): June 15, 16, 17, 18, 19, 23, 24, 25, 2015

This inspection was conducted concurrently with a Ministry of Health and Long Term Care Complaint Inspection Log #004273-15 and Ministry of Health and Long Term Care Follow-up Inspection Log #008310-15.

During the course of the inspection, the inspector(s) spoke with forty residents, the Administrator, the Corporate Regional Manager, the Resident Assessment Instrument(RAI)Coordinator, a Restorative Care Aide, a Wound Care Nurse-Registered Practical Nurse (RPN), Dietician, Physiotherapist, Food Services Manager, a Physiotherapist Assistant, a Registered Nurse, three Registered Practical Nurses, nine Personal Support Workers, a Personal Support Worker-Behaviour Supports Ontario, an Activity Coordinator, a Health Care Aide, a Maintenance staff, two Housekeeping aides, two Laundry aides, a Dietary Cook, the Residents' Council President, three family members and a Ward Clerk.

During the course of the inspection, the inspector(s)conducted a tour of all resident home areas, common areas, dining rooms, medication room, medication storage areas, observed the provision of resident care, resident-staff interactions, dining service, recreational activities, medication administration, reviewed relevant residents' clinical records, posting of required information, relevant policies and procedures, as well as meeting minutes pertaining to the inspection.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

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

Nutrition and Hydration

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Recreation and Social Activities

Reporting and Complaints

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

Sufficient Staffing

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

13 WN(s)
10 VPC(s)
1 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. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that the temperature of the water serving all bathtubs, showers and hand basins used by residents was 49 degrees Celsius or less.

This finding of non-compliance was previously issued as a Written Notification (WN) under O.Reg.79/10 s. 90 (2) (g),(h),(i),(k).

Record review of the Hot Water Temperature Log in 2015 revealed there were twenty documented water temperatures at the boiler that exceeded 49 degrees Celsius. The highest documented water temperature was 54 degrees Celsius documented seven times during this time frame. According to this record, hot water temperatures exceeded 49 degrees Celsius 43 % of the time.

Staff interview with the Maintenance staff member confirmed that boiler temperatures were taken daily and that there was no procedure or action implemented when boiler temperatures were noted to be above 49 degrees Celsius. [s. 90. (2) (g)]

2. The licensee failed to ensure that procedures were developed and implemented to ensure that the temperature of the hot water serving all bathtubs and showers used by residents was maintained at a temperature of at least 40 degrees Celsius.

Record review of an anonymous Ministry of Health and Long Term Care Complaint Information Report revealed a complaint that there was never enough hot water in the home.

Resident interviews related to tub/shower water temperatures during bathing revealed Resident #35 had a bath that day and shared that at times the water was cold and would prefer it to be warmer. Resident #11 shared the shower took a long time to get the water warm, but that the water in their bathroom rarely gets warm at the sink. Resident #48 shared that the water was warm enough but at times it was lukewarm and sometimes cool especially when it was cold outside.

Observation of the bathroom water supply at the sink of Resident #11 revealed the hot water tap was turned on and let run for two minutes without ever getting warm.

Record review of the "Union - Management Meeting Minutes" revealed the tub room water temperatures and strategies to stop the sudden surges of hot or cold water were discussed and proposals were presented to possibly correct the problem.

Record review of the "Water Temperature" Policy "The Temperature of hot water serving all bathtubs and showers used by residents shall be maintained at the temperature not below 40 C."

Record review of the “Caressant Care Mary Bucke – Tub Water Temperature” log revealed multiple daily water temperatures between 35 - 39 degrees Celsius in the tub rooms and on only one occasion did the temperature reach 40 degrees Celsius. One of the tub room water temperatures revealed 2.86 % of the time the hot water serving all bathtubs and showers used by residents was maintained at a temperature of at least 40 degrees Celsius.

Interview with the Administrator revealed the fluctuating water temperatures in the tub rooms have been an issue in the Nursing Home for numerous years. [s. 90. (2) (i)]

3. The licensee failed to ensure that if the home was not using a computerized system to monitor the water temperature, the water temperature was monitored once per shift in random locations where residents have access to hot water.

Staff interview with the Maintenance staff member confirmed water temperatures were not taken in the resident bathrooms, and were only taken in tub rooms. As well, the water temperature readings were not taken in random resident areas.

Staff interview with the Maintenance staff member confirmed the home was not using a computerized system to monitor the water temperature.

Record review of the "Water Temperature" Policy "Hot water temperature shall be monitored daily at the source once per shift in random locations where residents have access to hot water." [s. 90. (2) (k)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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. (8) The licensee shall ensure that the staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it. 2007, c. 8, s. 6 (8).

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 staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments were integrated, consistent with and complement each other.

A review of the clinical record revealed that Resident #47 fell a number of times in 2015.

A review of the progress notes revealed that Resident #47 had a decrease in their abilities in 2015.

An interview with a Personal Support Worker (PSW) confirmed that Resident #47 had a decrease in their abilities and that this information was relayed to the registered staff.

An interview with registered staff indicated that Resident #47 had a decrease in their abilities. Registered staff confirmed that no Physiotherapy referral was made to reassess the resident's current functional abilities.

An interview with Physiotherapy staff confirmed that it was the home's expectation that a referral should be made to Physiotherapy when a resident had a decline in physical functioning and that no referral for reassessment was completed for Resident #47 related to their continued decline in function and that one should have been made. [s. 6. (4) (a)]

2. The licensee failed to ensure that the provision of the care set out in the plan of care was documented.

Review of the most recent clinical record revealed that Resident #33 had a condition which required to be checked, monitored and recorded every shift (three times per day).

Review of Point of Care revealed five out of thirteen days (38%) on which there were two entries related to monitoring being recorded, and five out of thirteen days (38%) on which there were two entries related to care being provided.

Interview with a Registered Practical Nurse (RPN) confirmed that Point of Care (POC) documentation for Resident #33 was not completed and the expectation of the home was that documentation should be completed once per shift as per the Care Plan.

Interview with the Administrator confirmed that the expectation of the home was to follow the guidelines of the Care Plan and that documentation should be completed once in an eight hour shift. [s. 6. (7)]

3. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

Observations of Resident #47 revealed that the resident was wearing damaged and improperly fitted shoes. Further observation revealed that assistive devices were not within reach of the resident.

A review of the care plan revealed that Resident #47 was at increased risk of falls and in order to mitigate the risk, this resident was to have properly fitting shoes as well as

the call bell and commonly used items within reach.

An interview with a Personal Support Worker (PSW) and Physiotherapy staff confirmed that it was the home's expectation that the care provided was as specified in the plan of care and that for Resident #47 the care plan was not followed and should have been. [s. 6. (7)]

4. The licensee failed to ensure that the staff and others who provided direct care to a resident were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it.

Record review of the Minimum Data Set (MDS) Assessments dated in 2014 and 2015 for Resident #5 revealed a decline in ability to move about the home. The resident was independent without assistive aides on their admission date and now required physical assistance with one staff.

Record review of the current care plan revealed an absence of goals or interventions related to physical functioning and the type and level of assistance that was required relating to activities of daily living for mobility.

Record review of the Personal Support Worker (PSW) Kardex revealed the "Mobility" focus stated, "Locomotion On Unit" without resident specific interventions directing PSWs to provide care related to mobility.

Staff interview with the Registered Nurse (RN) confirmed the Kardex was the reference for PSW staff to provide care and services and confirmed the care plan for Resident #5 did not have goals or interventions in place related to physical functioning or staff assistance. The RN also confirmed the PSW Kardex lacked interventions related to mobility interventions for Resident #5.

Staff interview with the Personal Support Worker, confirmed there were no Kardex interventions in place related to mobility, physical functioning and staff support for Resident #5. [s. 6. (8)]

5. The licensee has failed to ensure that staff and others who provided direct care to a resident were kept aware of the contents of the plan of care and had convenient and immediate access to it.

A review of the MDS (Minimum Data Set) revealed activities and pursuits for Resident

#46 included numerous activities.

A review of the care plan revealed an absence of focus on activities or pursuits.

An interview with the Activity Coordinator confirmed that it was the home's expectation that activities and pursuits are to be outlined in the plan of care that was accessible to direct care staff.

An interview with the Resident Assessment Instrument (RAI)-Coordinator confirmed that direct care staff did not have access to MDS, or the care plans on the electronic documentation system and therefore would not have convenient and immediate access to information related to activities and pursuits for Resident #46. [s. 6. (8)]

6. The licensee failed to ensure that the staff and others who provided direct care to a resident were kept aware of the contents of the resident's plan of care and had convenient and immediate access to it.

Record review of the Minimum Data Set (MDS) Assessments for 2014 and 2015 revealed a decline in Resident #11's mobility. The resident was independent without assistive aides on their date of admission and now required staff assistance, and other types of physical assistance.

Record review of the current care plan revealed an absence of goals or interventions related to physical functioning and type and level of assistance that was required related to activities of daily living for mobility.

Record review of the Personal Support Worker (PSW) Kardex revealed the "Mobility" focus stated, "Locomotion On Unit" and an absence of specific interventions directing PSW's to provide care related to mobility. The Kardex and care plan were also absent of goals and interventions related to falls prevention and only made reference to an alerting mechanism with no further reference to any other interventions.

Record review of the Quarterly MDS Assessment, Resident Assessment Protocols (RAPs) revealed the resident required assistance, and had a history of falling. The RAP identified a care plan goal which included monitoring for any decline in function, while minimizing risk factors and staff assistance.

Observation of Resident #11 in their room revealed the resident was sitting and independently moving the chair without staff assistance. Later that day Resident #11

was observed walking using an assistive aide independent of staff assistance. A PSW intervened to remind the resident to ask for staff assistance.

Staff interview with the Resident Assessment Instrument (RAI) Coordinator confirmed an absence of Kardex interventions in place related to mobility and assistive devices, physical functioning and staff support for mobility for Resident #11. The RAI Coordinator also confirmed an absence of goals or interventions related to mobility. The RAI Coordinator confirmed that PSW staff do not have access to information and documentation outside of the Kardex in PointClickCare. [s. 6. (8)]

7. The licensee has failed to ensure that the resident 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 was no longer necessary.

A) A record review of the MDS (Minimum Data Set) revealed that activities and pursuits of Resident #44 included multiple interests.

A review of the care plan revealed no indication of activities and pursuits for Resident #44 and outlined a decrease in the resident's functioning.

A review of the Physiotherapy assessment revealed that Resident #44 had returned to baseline.

An interview with the Activity Coordinator confirmed that it was the home's expectation that the care plan was to be updated when the resident's care needs changed. The Activity Coordinator confirmed that the information contained in the care plan was outdated and did not address the impact of the resident's decline on activities and pursuits nor outlined the resident's current activities and pursuits.

B) Record review of the Dietary and Nursing, Care Plan detail for Resident #25 revealed the resident had a condition.

Record review of Progress notes for 2014 and 2015 revealed documentation related to the condition.

Record review of the most recent Minimum Data Set (MDS),revealed an absence of documentation related to historic or current conditions.

Interview with a Registered Practical Nurse (RPN) revealed that Resident #25 had a

condition which was currently resolved, and that the were staff monitoring it daily. The RPN confirmed that the Care Plan for Resident #25 was not up to date with the inclusion of "daily monitoring" of the condition, nor upon review, was it currently listed on the Kardex.

The RPN confirmed that the expectation of the home was that the Care Plan, MDS and Kardex should be up to date with current treatments, and measures. [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 to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other; that the provision of the care set out in the plan of care is documented; that care set out in the plan of care is provided to the resident as specified in the plan; that staff and others who provide direct care to a resident are kept aware of the contents of the resident's plan of care and have convenient and immediate access to it; that the resident is 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, to be implemented voluntarily.

WN #3: 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 the "Pain Assessment" Policy was complied with.

This finding of non-compliance was previously issued as a Voluntary Plan of Correction (VPC) under LTCHA, 2007, under O.Reg.79/10, s.8.(1)(b) on August 1, 2012, Inspection #2012_090172_0040.

Record review of the "Pain Assessment" Policy "Residents who score a two (2) or higher on any MDS RAI assessment under section J2 will have a further pain assessment completed using the Caressant Care Pain Assessment Tool on Point Click Care."

Record review of the Quarterly Minimum Data Set (MDS) Assessment revealed that Resident #3 had an increase in frequency of moderate pain as documented in section J2 "Pain Symptoms." Previously, Resident #3 was documented as experiencing moderate pain less than daily in the MDS Assessment and now the pain occurred daily.

Record review of the Pain Scale scores from the MDS Assessments revealed that Resident #3 had a pain score of two on three occasions in 2015. Record review of the "Caressant Care (CC) Pain Assessment Tool" revealed it was completed in PointClickCare (PCC) on two occasions in 2014.

Staff interview with the Registered Nurse confirmed Resident #3 did not have a CC Pain Assessment Tool completed on Point Click Care when the resident's Pain Score was two or greater. [s. 8. (1) (a),s. 8. (1) (b)]

2. The licensee has failed to ensure that the Skin Integrity Policy was complied with.

Record review of the Skin Integrity Policy revealed "Registered staff shall utilize the E-TAR (Electronic Treatment Administration Record) on Point Click Care and other programs to document and assess treatments and progress of conditions."

Progress note revealed Resident #25 had a condition in 2014.

Record review revealed the absence of documentation related to the condition for this specific time period in 2014.

Record review of the current care plan revealed a condition.

Record review of progress notes in 2014 and 2015 revealed documentation related to the condition.

Interview with the Registered Practical Nurse (RPN) revealed that Resident #25 had a condition that was resolved and that the staff monitored it daily. The RPN confirmed the historical look back in Point Click Care completed for the specific time period as having absent documentation.

The RPN confirmed that the expectation of the home was that documentation should be completed in terms of assessment of treatment and progress, when a resident has a condition. [s. 8. (1) (a),s. 8. (1) (b)]

3. The licensee has failed to ensure that the "Resident Behaviour Management" Policy was complied with.

Record review of the "Resident Behaviour Management" Policy "If a resident is exhibiting a behaviour that is identified by staff to be disruptive or potentially injurious to the resident or others, a responsive behaviour tracking record will be initiated and completed over 72 hours. At the end of the 72 hours, the flow sheet will be given to the charge nurse to be assessed."

Record review of the progress notes, Minimum Data Set (MDS) and Resident Assessment Protocol (RAPs) demonstrated Resident #5 exhibited responsive behaviours identified by staff.

Staff interview with the Registered Nurse confirmed Resident #5 did not have a responsive behaviour tracking record initiated for any of the triggered responsive

behaviours identified in the resident's clinical record since admission. [s. 8. (1) (b)]

4. The licensee has failed to ensure that the "Expiry and Dating of Medications" Policy #5-1 was complied with.

Record review of the "Expiry and Dating of Medications" Policy #5-1 "Designated medications i.e. eye drops, insulin, must be dated when opened and removed from stock when expired." "Remove any expired medications from stock and order replacement if necessary."

Observation of the Medication Room revealed the medication storage area for government stock medications had expired items present.

Staff interview with the Registered Nurse (RN) confirmed stock drugs were checked for expiry dates monthly by a registered staff member. Interview with the Administrator confirmed it was the home's expectation that the expiry date of all medications be checked regularly and removed from stock when expired. [s. 8. (1) (b)]

5. The licensee failed to ensure that the "Medication Pass" Policy was complied with.

Record review of the "Medication Pass" Policy #3-6 revealed, “Find Medication Administration Record (MAR) for the resident and identify medications for the pass time. Check each medication label against MAR to ensure accuracy.”

Medication observation revealed a Resident walked past the medication cart that was parked in the hallway. At that time, the Registered Practical Nurse (RPN) dispensed a medication from a clear pill container for this resident without the resident’s electronic (e)MAR available on the screen. The eMAR computer screen displayed a different resident’s profile.

Observation of the medication container in the med cart and the physician's order in eMAR revealed the pill container for Resident #6 contained capsules with directions on the label.

A Registered Practical Nurse and the Administrator confirmed that during medication administration, the resident’s eMAR profile should be displayed to registered nursing staff for the identification of medications and accuracy of administration. [s. 8. (1) (b)]

6. The licensee failed to ensure that the "Lost Clothing" Policy was complied with.

Record review of the "Lost Clothing" Policy revealed staff are to "ensure inventory of personal affects is up to date and new items marked on the list as residents receive them."

Resident interviews during stage one of the Resident Quality Inspection revealed three residents reported several articles of missing clothing.

Staff interview with the Regional Manager and a Personal Support Worker confirmed the home does not complete an initial inventory of clothing on admission or when a resident receives new items. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Pain Assessment, Wound Assessment, Resident Behaviour Management, Expiry and Dating of Medications, Medication Pass, and the Lost Clothing Policies, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007, 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 that the home, furnishings and equipment were kept clean and sanitary.

Observation of the Medication Room revealed the medication refrigerator had debris on the shelves, racks, door seams, and door. Both the interior and exterior of the refrigerator were unclean.

Staff interview with the Registered Nurse confirmed the medication refrigerator was not kept clean and sanitary and the fridge was required to be cleaned once a week on Saturdays. There was no documented evidence when the refrigerator was last cleaned.

Record review of the "RN Night Duties" revealed, "Saturday: defrost and clean fridges in med room and in clean utility room."

Staff interview with the Administrator confirmed the refrigerator was unclean and should be cleaned weekly by a registered staff member. [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.

This finding of non-compliance was previously issued as a Voluntary Plan of Correction (VPC) under LTCHA, 2007, S.O. 2007, c.8,s.15 on January 20, 2014, Inspection #2014_232112_0003.

Record review of an anonymous Ministry of Health and Long Term Care Complaint Information Report revealed concerns that the roof in the home was leaking.

Staff interview with the Administrator revealed areas of the ceiling and roof had damage and the roof had a tarp in place to avoid further water leaks. The Administrator shared that water leaked from the roof into the dining room area and the Administrator's office space when the snow and ice started to melt in the spring of 2015.

Record review of email correspondence between the home, contractors, and the Regional Environmental Supervisor revealed three contractors had inspected the roof and had recommended a new roof and a fourth quote was pending.

Interview with the Maintenance staff member revealed the origin of the leak was unknown. [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 to ensure that the home, furnishings and equipment were kept clean and sanitary and maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan included a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work.

A review of the home's staffing plan revealed an absence of a back-up plan for nursing and personal support staff that addresses situations when staff cannot come to work.

An interview with the Administrator confirmed that when a Personal Support Worker (PSW)
shift was unable to be filled, the staff that were present at that time collaborate together to decide how the care duties would be covered. The Administrator confirmed that the home did not have a written back-up plan to address when staff cannot come to work. Legislation related to staffing plans was reviewed with the Administrator who confirmed that it was the expectation that a written staffing back-up plan be implemented and that this did not occur and should have. [s. 31. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the staffing plan includes a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that strategies have been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

Observation of Resident #5 revealed the resident was exhibiting responsive behaviours. The Administrator was able to address the behaviours with the resident.

Record review of the progress notes revealed Resident #5 had been displaying since 2014.

Record review of the progress notes revealed Resident #5 had displayed responsive behaviours since 2015. Documentation demonstrated six separate episodes of responsive behaviours in the past four months. The progress notes clearly describe the responsive behaviours.

Record review of the Minimum Data Set (MDS) Assessments revealed the Resident Assessment Protocol (RAP) clearly describe the responsive behaviours.

Staff interview with a Personal Support Worker (PSW) confirmed an absence of interventions implemented to respond to Resident #5 who demonstrated the responsive behaviours.

Staff interview with the Registered Nurse (RN)confirmed the Kardex was the reference for PSW staff to provide care and services and confirmed an absence of goals or interventions developed or implemented specific to the responsive behaviours identified in the progress notes, MDS and RAPs. The RN shared that there should be

strategies to respond to the resident demonstrating these behaviours.

Staff interview with the Personal Support Worker, Behaviour Supports Ontario (BSO PSW)confirmed that Resident #5 was not a part of the BSO Program, there has never been a referral for BSO for this resident and also shared that the BSO team was unaware of Resident #5"s responsive behaviours. [s. 53. (4) (b)]

2. The licensee has failed to ensure that strategies been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible.

Record Review of Minimum Data Set (MDS) revealed that Resident #36 had demonstrated responsive behaviours.

Record review of Point of Care (POC) revealed that Resident #36 showed signs of responsive behavior on multiple occasions.

Record review of the most recent Care Plan revealed that there was an absence of a focus, goals, and interventions related to responsive behaviours.

Interview with a Personal Support Worker, Behaviour Supports Ontario (PSW BSO) revealed that Resident #36 has had BSO involvement in the past and strategies had been developed unrelated to the present responsive behaviours and the expectation of the home was that the identified behaviours and strategies should have been in the care plan. [s. 53. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that strategies have been developed and implemented to respond to the resident demonstrating responsive behaviours, where possible, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007, s. 76. Training
Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations.

A review of the 2014 mandatory training logs revealed that 60 percent of all the registered staff completed the mandatory training related to infection control.

A review of the 2014 mandatory training logs for all non-registered staff of the home revealed 74 percent completed the infection control training.

An interview with the Southwestern Regional Manager confirmed that it was the expectation of the home that all staff were to complete all mandatory, and annual training as applicable by department, that all registered and non-registered staff did not complete mandatory, and annual training in infection control for the 2014 calendar year. [s. 76. (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 to ensure that persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home has been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint.

An interview with Resident #44 revealed that a verbal complaint was made to staff regarding a missing item and over the course of several weeks the items were not located.

An interview with the Administrator confirmed that the complaint was received and the home attempted to resolve the issue. The Administrator confirmed that no written response was provided to the complainant.

A review of the home's policy titled "Complaints Process" effective date March 2012 revealed that all complaints were to be responded to within 10 business days.

In an interview, the Administrator confirmed that in the case of the complaint regarding missing items by Resident #44, that the home did not respond to the complaint and should have. [s. 101. (1) 1.]

2. The licensee has failed to ensure that a documented record was kept in the home that included:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant.

An interview with Resident #44 revealed that a verbal complaint was made to the home regarding missing personal property.

An interview with Registered Staff revealed that staff were unaware that verbal complaints were to be communicated to the Administrator. The Registered Staff was unable to provide an explanation of how verbal complaints were tracked.

An interview with the Administrator confirmed that no records of verbal complaints were kept by the home and that no record was available of the complaint made by Resident #44 regarding missing items. The Administrator confirmed that no records of verbal complaints were kept by the home and that no record was available of the complaint made by Resident #44 regarding missing items.

The home's policy titled "Complaints Process" revealed that it was the home's expectation that a record of all verbal complaints were to be maintained by the home.

In an interview, the Administrator confirmed that the home did not have a verbal complaint tracking record. The Administrator confirmed that no written record of the complaint by Resident #44 was kept and should have been. [s. 101. (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 to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint, and that a documented record is kept in the home that includes:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any, to be implemented voluntarily.

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 was secure and locked and controlled substances were stored in a separate locked area within the locked medication cart.

Medication observation revealed the medication cart was unlocked and unattended on three separate occasions.

Observation of the interim Medication Room revealed the medication cart was unlocked. The Medication Room was under construction and the Activity Room had been appointed the interim Medication Room. The Registered staff confirmed certain medications were stored in separate locked areas within the medication cart, however the medication cart was unlocked.

Observation of the Medication Room revealed the medication cart was unlocked. The Registered staff confirmed that the specific medications were not stored in a separate locked area within the locked medication cart.

Staff interview with the Administrator confirmed specific medications were to be stored in a separate locked area within the locked medication cart. [s. 129. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in an area or a medication cart that is secure and locked and controlled substances are stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that training in Falls Prevention and Management was provided to all staff who provide direct care to residents.

A review of the 2014 mandatory training logs revealed that 46 percent of all the registered staff completed the mandatory training related to falls prevention.

Multiple observations made during the course of the Resident Quality Inspection revealed housekeeping staff assisted residents to and from the dining room. The Administrator confirmed that at times the housekeeping staff assisted residents to and from the dining room due to the size of the home and that this would constitute direct care to residents.

A review of the 2014 mandatory training logs for all housekeeping staff revealed that these staff had not completed the mandatory training in falls prevention.

An interview with the Southwestern Regional Manager confirmed that it was the expectation of the home that all staff were to complete all mandatory training as applicable by department, that all registered staff did not complete mandatory training in falls prevention and should have.

The Southwestern Regional Manager also confirmed that it was the home's expectation that all housekeeping staff were to receive annual training in falls prevention and in the case of the 2014 calendar year, no housekeeping staff received falls prevention training and should have. [s. 221. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that training in Falls Prevention and Management is provided to all staff who provide direct care to residents, to be implemented voluntarily.

WN #11: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff participated in the implementation of the infection prevention and control program.

Observations made during the course of the inspection revealed communal bathrooms contained:
- unlabeled urine collection container on top of toilet tank,
- unlabeled toothbrush,
- unlabeled bedpan noted on the back of the toilet,
- unlabeled urinal stored on toilet tank.

Observations during the initial tour of the home revealed:
- home care area "Tub Room" had two used and unlabeled hair brushes, five combs and two used and unlabelled jars of a specific cream
- resident home care area "Tub Room" had one used and unlabeled black comb noted on top of towel warmer

Interview with two Personal Support Workers (PSW) confirmed that all personal care items used by residents should be labeled and stored in the resident's room and not in the tub rooms.

Interview with the Administrator confirmed it was the expectation of the home that all personal care aids were to be labeled and if soiled, taken to the dirty utility room for cleaning and storage. The Administrator also confirmed that all personal care items should be labeled with the resident's name. [s. 229. (4)]

2. Medication observation revealed the Registered staff had contact with multiple residents and did not perform hand hygiene between residents. During the medication observation, the Registered staff removed medication from a capsule casing, and dropped the casing on the floor. The Registered staff picked it up, discarded the casing in the garbage and proceeded to administer medication with no hand hygiene before or after contact with the garbage and the floor.

The Administrator confirmed that hand hygiene should be performed between residents and after contact with the garbage and the floor. [s. 229. (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 to ensure that staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that resident's personal health information within the meaning of the Personal Health Information Protection Act, 2004 was kept confidential.

Observation revealed an unlocked and unattended privacy screen on the Point of Care terminal which exposed Personal Health Information. The Food Services Manager confirmed that the expectation of the home was that the terminal should be locked when there was no one in attendance. (588)

Observation of medication administration revealed the privacy screen on the Point of Care terminal attached to the medication cart was open, unattended, and displayed Personal Health Information related to medications and diagnoses which was visible to several people walking by. This occurred on three separate occasions during the administration of medications.

Staff interview with the Registered staff confirmed that the Privacy screen lock needs to be engaged when the terminal is unattended. (563) [s. 3. (1) 11. iv.]

WN #13: The Licensee has failed to comply with LTCHA, 2007, s. 59. Family Council

Specifically failed to comply with the following:

s. 59. (7) If there is no Family Council, the licensee shall,
(a) on an ongoing basis advise residents' families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).
(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that when there was no Family Council, that the licensee convened semi-annual meetings to advise residents' families and persons of importance to residents of their right to establish a Family Council.

An interview with the Activity Coordinator confirmed that there has not been a Family Council in the home for one year. Since that time there has not been any semi-annual meetings to advise residents’ families of their right to establish a Family Council.

An interview with the Administrator confirmed that it was the home’s expectation that residents’ families are advised of their rights to establish a Family Council. The Administrator confirmed that semi-annual meetings to inform families of their rights related to Family Council did not occur and should have. [s. 59. (7) (b)]

Issued on this 12 day of January 2016 (A1)

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

Ministère de la Santé et des Soins de longue durée

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

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

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130 Dufferin Avenue, 4th floor
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Télécopieur: (519) 873-1300

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : CHRISTINE MCCARTHY (588) - (A1)

Inspection No. / No de l'inspection : 2015_355588_0015 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 010393-15 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : Oct 30, 2015;(A1)

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 ON MARY BUCKE
4 MARY BUCKE STREET, ST. THOMAS, ON, N5R-5J6

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Kori Amon

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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:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,

(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;

(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;

(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;

(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;

(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;

(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;

(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and

(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Order / Ordre :

(A1)
The licensee shall ensure that procedures are developed and implemented to ensure that the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature; the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius; and if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79 10, s. 90 (2).

Grounds / Motifs :

1. The licensee has failed to ensure that procedures are developed and implemented to ensure that the temperature of the water serving all bathtubs, showers and hand basins used by residents is 49 degrees Celsius or less.

Previously issued as a Written Notification (WN) under O.Reg.79/10 s. 90(2) (g),(h), (i),(k).

Record review of the Hot Water Temperature Log in 2015 revealed that there were twenty documented water temperatures at the boiler which exceeded 49 degrees Celsius. The highest documented water temperature was 54 degrees Celsius, which was documented seven times during this time frame. According to this record, hot water temperatures exceeded 49 degrees Celsius 43% of the time.

Staff interview with the Maintenance staff member confirmed that boiler temperatures were taken daily and that there was no procedure or action implemented when boiler temperatures are noted to be above 49 degrees Celsius.
(563)

2. The licensee failed to ensure that procedures are developed and implemented to ensure that the temperature of the hot water serving all bathtubs and showers used by residents was maintained at a temperature of at least 40 degrees Celsius.

Record review of an anonymous Ministry of Health and Long Term Care Complaint Information Report revealed a complaint that there was never enough hot water in the home.

Resident interviews related to tub/shower water temperatures during bathing revealed Resident #35 had a bath that day and shared that at times the water was cold and would prefer it to be warmer. Resident #11 shared that the shower takes a long time to get the water warm, and that the water in their bathroom rarely gets warm at the sink. Resident #48 shared that the water was warm enough but at times it was lukewarm and sometimes cool especially when it was cold outside.

Observation of the bathroom water supply at the sink of Resident #11 revealed the hot water tap was turned on and let run for two minutes without ever getting warm.

Record review of the "Union - Management Meeting Minutes" held April 28, 2015 revealed the tub room water temperatures and strategies to stop the sudden surges of hot or cold water were discussed and proposals were presented to possibly correct the problem.

Record review of the "Water Temperature" Policy revealed, "The Temperature of hot water serving all bathtubs and showers used by residents shall be maintained at the temperature not below 40 C."

Record review of the “Caressant Care Mary Bucke – Tub Water Temperature” log revealed multiple daily water temperatures in the tub rooms were documented and had temperatures of 35 - 39 degrees Celsius. On only one occasion did the temperature reach 40 degrees Celsius. One of the tub rooms water temperatures revealed 2.86 % of the time the hot water serving all bathtubs and showers used by residents was maintained at a temperature of at least 40 degrees Celsius.

Interview with the Administrator revealed the fluctuating water temperatures in the tub rooms have been an issue in the Nursing Home for numerous years.
(563)

3. The licensee failed to ensure that if the home was not using a computerized system to monitor the water temperature, the water temperature was monitored once per shift in random locations where residents have access to hot water.

Staff interview with the Maintenance staff member confirmed water temperatures were not taken in the resident bathrooms, and were only taken in tub rooms. As well, the water temperature readings were not taken in random resident areas.

Staff interview with the Maintenance staff member confirmed the home was not using a computerized system to monitor the water temperature.

Record review of the "Water Temperature" Policy "Hot water temperature shall be monitored daily at the source once per shift in random locations where residents have access to hot water."
(563)

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

Dec 27, 2015(A1)

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
Toronto ON M5S 2B1
Télécopieur : 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
Toronto ON M5S 2B1
Télécopieur : 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 12 day of January 2016 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : CHRISTINE MCCARTHY - (A1)

Service Area Office /
Bureau régional de services : London