Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 17, 2014	2014_365194_0024	O-000667-14	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 MCLAUGHLIN ROAD
114 McLaughlin Road LINDSAY ON K9V 6L1

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

CHANTAL LAFRENIERE (194), AMANDA NIXON (148), KARYN WOOD (601), LYNDA BROWN (111), MARIA FRANCIS-ALLEN (552)

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 17, 18, 19, 10, 21, 24, 25, 26, &27, 2014

During the course of this inspection 4 Complaint Inspections, Logs #000934-14, #000971-14, #001046-14 and #001062-14, 2 Critical Incident Inspections, Logs #001114-14 and #006794-14 and a Follow-Up Inspections, Log #000886-14 were completed.

During the course of the inspection, the inspector(s) spoke with Administrator, Administrative Assistant, Director of Care (DOC), Resident Care Co-ordinator (RCC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers(PSW), Activity Director, Environmental Services Manager (ESM), Housekeeping staff, RAI Co ordinator, Wound care nurse, Laundry Aide, President of Resident and Family Councils, Residents and Family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Laundry
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

12 WN(s)
6 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #002	2014_360111_0018	111
LTCHA, 2007 S.O. 2007, c.8 s. 20. (1)	CO #003	2014_360111_0018	111

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. 8. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one Registered Nurse who is an employee of the licensee and a member of the regular nursing staff is on duty and present at all times unless there is an allowable exception to this requirement

The staffing schedules for Registered Nurses for the period of September 01, 2014 to November 16, 2014 indicated that 18 (12 hours shifts) and 5 (8hour) shift did not have Registered Nurses on duty and present in the home.

DOC stated that the home has been attempting to recruit for additional Registered Nurses and has not been successful, they have recently received some Registered Nurse applicants and are in the process of interviewing. [s. 8. (3)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with 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 provided for a staffing mix that is consistent with the resident's assessed care need related to bathing and included a back up plan for personal care staffing that addresses situations when staff cannot come to work.

Interview with DOC confirmed that one of the home's "bath shift positions " had been vacant for some time. DOC stated that attempts to fill the position had been made but that the home had been unsuccessful. The position is currently filled. A review the staff schedules for the period of September 2014 to October 2014 was completed, indicating that for the month of September 2014 a total of 26 bath shifts were not staffed and in October at total of 19 baths shifts were not staffed.

The responsibility of the bath shift position is to provide baths to residents on the unit according to the bath schedule, which enable the unit to provide 2 baths a week to residents.

Interview with PSW # 121 who is the bath person on unit # 2 indicated that she has been pulled from the bath shift position to cover on the unit as a PSW staff if someone calls in sick.

During and interview PSW #117 indicated that when the bath shift person calls in sick and is not replaced baths are not completed on the unit. PSW #117 stated that the bath person called in sick on her unit on an identified date and was not replaced.

Interviews with Resident's # 41 #45, # 47, # 03, #24 indicated that their baths had not been provided related to staff not being available.

Review of the Resident Council minutes for the month of August 2014 indicated that a concern was brought forward by the Council about baths being missed and the concern that there was not enough staff on the unit to provide the baths.

The DOC has indicated that a back up plan had not been developed or implemented for PSW staff, when the bath shift position cannot be staffed on the unit to accommodate residents baths. [s. 31. (3)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear direction to staff and others who provide direct care to the resident regarding bedtime routines.

During the Resident Quality Inspection (RQI), interview of the family member stated "sometimes staff are not putting [Resident #22] down for a nap in the afternoon as [Resident #22] is tired and it is on the care plan to be put down for a nap in the afternoon".

Interview of PSW #112 indicated that Resident #22 usually gets up between 6:30 -07:00

hrs. The resident is usually put to bed after lunch for a rest.
Observation of Resident #22 on two identified dates indicated the resident was observed in bed after lunch.

Review of the current care plan for Resident #22 indicated:
-related to bedtime routine: generally will go to bed at 1900 to 2000 hrs, staff to provide extensive assistance when ready for bed at night.

The care plan does not provide clear direction regarding the residents need for rest periods after lunch. [s. 6. (1) (c)]

2. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care related to toileting so that the care is integrated and consistent

Log # 006193 related to Resident # 042

The plan of care for Resident #42 related to toileting directs that the resident uses a bedpan when in bed at HS. Staff to assist with positioning and removing the resident from the bedpan.
- Staff to monitor when the resident is using the bedpan as there is a history of falling asleep on it.
- The resident uses the bedpan at HS and will ring the bell when assistance is needed.

On an identified date, the resident was assisted by the RPN onto a bedpan at the resident's request. The RPN did not communicate the information to the PSWs on the unit. Resident #42 subsequently fell asleep. The resident is not awakened by staff on the 1st round of the night shift as the resident is not usually incontinent. The resident was found by a PSW approximately six hours later partially sitting on the bedpan. The resident did not suffer any injury. [s. 6. (4)]

3. The licensee has failed to ensure that the plans of care for Residents #22 and #12 provided care to the resident as specified in the plan related to personal laundry and wound care treatment.

During stage 1 of the RQI, interview of the Substitute Decision Maker(SDM) indicated that a couple of months ago, Resident #22 had a pair of black pants go missing and was

reported to staff but was never found. The SDM indicated that they were upset because the clothing should not have been removed as the family does the resident's laundry.

Review of the health care record for Resident #22 indicated:
-care plan related to dressing: POA takes all personal laundry home to be washed; staff to place in laundry basket in room for family; family returns and will alert staff when unable to do laundry.
-progress notes indicated on an identified date "Family do resident's laundry. Note left pinned to closet door". Resident missing a black or blue pair of pants. POA went to search in laundry with no effect. Will keep looking. Family do resident's laundry at home. [s. 6. (7)]

4. -The plan of care for Resident #12 indicates a physician's order related to a change in wound care treatment.

Review of Treatment Administration Record (TAR) for the period of two months, indicates no dressing changes were provided for Resident #12 for three identified dates as directed by the Physician order.

Interview with two RPN’s #103 and #123 working the evening shift responsible for dressing change scheduled for 1900 hours, indicated that the dressing for Resident #12 had not been completed. RPN #103 stated that the dressing had not been completed as the Physician's order had not been transcribed to the TAR. [s. 6. (7)]

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 there is a written plan of care for each resident
-that sets out clear direction for the resident
-that the care is provided to the resident as set out in the plan
-that staff collaborate with each other in the development and implementation of the plan of care, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were bathed at a minimum, twice a week by the method of his or her choice.

During and interview PSW #117 indicated that when the bath shift person calls in sick and is not replaced baths are not completed on the unit. PSW #117 stated that the bath person called in sick on her unit on an identified date and was not replaced.

Review of the bathing schedule for Unit 1 indicated that Resident's #3,#24,#27 and #47 were to be bathed on an identified date.

Interview with the above noted residents indicated that no baths were conducted on this day and the baths were not completed on the following day. All resident's except for Resident #27 were upset about missing their baths. [s. 33. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that residents are bathed at a minimum of twice a week by the method of his or her choice., to be implemented voluntarily.

WN #5: 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 the residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, have been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident # 12 was admitted to the home on an identified date with wound care requirements. Skin assessments were documented on the admission with no indication of any infection to the areas.

Approximately one month after admission a wound consult from an(Enterstomal)ET Nurse identified a change in wound treatment including the need for antibiotics related to an infection.

DOC informed inspectors that the lead position for wound care in the home was in transition. The DOC stated that the home's practice related to documentation for wound care required that the Registered Nursing staff complete weekly skin assessment in the Progress notes in Point Click Care(PCC).

RPN #103 and RPN #123 indicated that they were unclear who was to complete the weekly wound assessment.

The clinical health record for Resident #12 did not provide for any wound care assessments being completed for approximately two months. [s. 50. (2) (b) (iv)]

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 residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home.

Inspector #148 spoke with two members of the Resident Council, Resident #38 and Resident #41, who both indicated they did not have knowledge of having received a satisfaction survey in the last year.

The home's Administrator confirmed that a satisfaction survey was distributed early October 2014. Upon further discussion, the Administrator described that the survey was distributed by mail through the home's billing processes and was sent to the person

responsible for the resident's finances. The home's Administrative Assistant was involved with the distribution of the satisfaction survey in October 2014. Information provided by the Administrative Assistant indicates that a total of five residents were provided the satisfaction survey in October 2014. In the case of all other residents in the home, including Resident #38 and #41, the satisfaction survey was not provided to the resident but rather to the person responsible for the resident's finances.

The home has 96 licensed beds; the October 2014 survey was not distributed to all capable residents nor was the survey distributed to all resident families. Further to this, as of November 20, 2014, the home was also unable to confirm if a survey was distributed in 2013. [s. 85. (1)]

2. The licensee failed to seek the advice of the Residents' and Family Councils in developing and carrying out the survey.

Inspector #148 spoke with the home's Resident Council President, Resident #41, who indicated that he/she was unaware of a satisfaction survey having been completed in the home.

Inspector #601 spoke with the home's Family Council President, who reported a satisfaction survey had been implemented in the home, but did not recall the home seeking the advice of the Family Council in the development and carrying out of the survey.

Inspectors confirmed with the home's Administrator that the home implemented a satisfaction survey in early October 2014. The Inspectors spoke with the Administrator and the Activity Director, the liaison for both Councils, and it was reported that the home did not seek the advice of the Resident or Family Council in developing and carrying out the survey. [s. 85. (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 by ensuring that at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home., to be implemented voluntarily.

WN #7: 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,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented for cleaning of the home, including, common areas and staff areas, floors, carpets, furnishings, contact surfaces and wall surfaces.

During observations on November 17, 18 & 19, 2014 on both unit 2 and unit 3 there were 3 large ceiling fans and 1 large floor fan in use. All of the fans were heavily soiled with dirt and debris.
Observation of the all the tubs room floors on unit 1,2 & 3 on November 18 & 19, 2014 were heavily soiled with dirt.

Interview of (House Keeping Staff)HSK# 100 (unit 3) on November 17, 2014 indicated that there was no cleaning schedule in place for the ceiling and floor fans and that the tub room floors are dry and wet mopped daily. HSK #100 indicated the ceiling/floor fans "are

not cleaned very often and were last cleaned approximately 2 months ago" but not by the housekeeping. Interview of HSK #104 (unit 2) on November 20, 2014 indicated that the Environmental Supervisor "cleans all the fans but if we see they are dirty we will give them a wipe". HSK#104 indicated the tub room floors are washed with mop, water and RSO cleaner. HSK#104 indicated the floors are "burnished" or deep cleaned using a machine but is completed by evening students "once in awhile".

Interview of Environmental Services Manager (ESM)on November 20, 2014 indicated that he cleans all ceiling fans throughout the home at the end of the month and indicated that Registered staff clean the floor fans. The ESM indicated there was no documented evidence of fans being cleaned nor a policy/procedure regarding the cleaning of fans in the home. The ESM indicated that the tub room floors are cleaned daily (7 days/week) by housekeeping but "because they are used more frequently than the shower rooms and the spray from the tub disinfectant used by PSW's and the floors are old, the floors are difficult to keep clean". The ESM indicated the "burnishing" or deep cleaning of the floors is done by the housekeeping students and there is no policy regarding the procedure.

Interview of RPN #103 & 106(unit 2 & 3) indicated they were not aware they were responsible for cleaning of floor fans and thought it was the responsibility of housekeeping.

Review of the "daily tasks" from January to November 2014 indicated the tub room floors are cleaned daily (7 days/week) by housekeeping staff on each unit. Review of the cleaning schedule for the student housekeepers (4-8pm 7 days/week) indicated the "burnishing" or deep cleaning of the tub room floors is completed on Fridays. Review of these cleaning schedules from January to November 2014 indicated 16 weeks when the deep cleaning of the tub room floors were not completed.

Review of the homes policy "cleaning guideline -tub rooms" (reviewed February 2013) indicated all tub rooms shall be thoroughly cleaned daily which includes dry/wet mop floors. There was no indication of "burnishing" or deep cleaning of tub room floors or a procedure on how this was to occur. [s. 87. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring that procedures were developed and implemented for cleaning of the home, including, common areas and staff areas, floors, carpets, furnishings, contact surfaces and wall surfaces., to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the documentation of restraints included all assessment, reassessment, monitoring, and the resident's responses.

Resident #23 was observed on November 20, 2014 to have a front closure seat belt in place while up in the wheelchair which the resident was unable to remove.
Review of the care plan for Resident #23 indicated the resident required the use of seat belt restraint while up in wheelchair for safety due to history of frequent falls.

Resident #19 was observed by Inspector #148 to have a front closure lap belt applied when seated in his/her geri-chair. The resident's health care record indicated that the lap belt is used as a restraint to mitigate the risk of falls and injury to self.

Resident #29 was observed by Inspector #601 to have a front closure lap belt applied when seated in his/her wheelchair. The Resident's health care record indicated that the lap belt is used as a restraint to mitigate the risk of falls and injury to self.

Interview of PSW #105 indicated that the application, removal, monitoring, and repositioning of resident restraints is completed electronically on Point of Care (POC) under restraints. PSW #105 indicated that they would select either "no" or "not applicable" when restraint not in use.

Review of the POC for Resident #23, #19 and #29 and under restraints (November 2014) indicated there are three questions to be completed related to use of restraints:
Question #1-Is the restraint in use?(Responses:yes, no, resident not available, resident refused, not applicable);
Question#2-q1hr safety check and/or q2h repositioning completed?(Responses:yes, no, resident not available, resident refused, not applicable);
Question #3 -Resident response? (Responses: calm, agitated, sleeping, not available, refused, not applicable).
The times documented ranged from hourly to every five hours, and it did not indicate whether the time selected was for "checking" the resident or for "repositioning" the resident.

Interview of the DOC confirmed that the documentation related to monitoring of restraints was not being documented hourly, it was unclear why staff use either a "no" or "not applicable" when the restraint is not in use, and was unable to indicate whether the resident was being checked or repositioned. [s. 110. (7) 6.]

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 are monitored while restrained at least every hour and that residents are released from the physical device and repositioned at least once every two hours., to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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:
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to designate a person to receive information concerning any transfer or any hospitalization of the resident, was fully respected and promoted as that person did not receive that information immediately.

On September 19, 2014, during a family interview during the RQI, the family member stated "approximately two months ago [Resident #22] was sent to hospital for change in condition and they only called my home number and left message. I was upset because they did not call the cell phone number which was provided and I didn't get the message for over two hours until I returned home and got the message. I called the home and then rushed to the hospital".

Review of Resident #22 profile on Point Click Care(PCC) had two Power of Attorney (POA) emergency contacts which included both home phone, cell phone and "other" phone numbers available.

Review of progress notes for Resident #2 indicated on an identified date the RPN was informed by unit nurse that the resident presented as unwell. VS were taken and reviewed resident's chart and Level 3 Do Not Recesitate (DNR) transfer status. Requested admin assistant contact management. Writer called physician, confirmed nurse should send to ER. Unit nurse placed call to POA, no answer, message left. 911 called, paramedics on site within 6-7 min. Approximately 6 hours later the RPN spoke with POA regarding residents condition. Resident returned to home later in the evening. [s. 3. (1) 16.]

WN #10: 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. Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that, is on at all times.

Log # 006193
A Critical incident was received indicating that on an identified date, Resident #42 was in bed and used the call bell to alert staff that assistance was required to use the bathroom. The RPN responded and gave the resident the bedpan. Approximately 8 hours later, a PSW found the bedpan partially under the resident's buttocks with no injury. The resident is cognitively intact but has some physical limitations.
During the home's internal investigation the resident was interviewed and was able to recall the incident. When asked why the call bell was not used to alert staff that the resident had finished using the bedpan, the resident stated that the call bell was activated but no one responded.
Review of the investigation records indicate that the resident indicated to the management team that the call bell was activated several times after using the bed pan but no one responded. The resident was asked to ring the call bell and it was discovered that the call bell was not working. [s. 17. (1) (b)]

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a care conference of the interdisciplinary team was held to discuss the plan of care and any other matters of importance to the resident and his or her Substitute Decision Maker(SDM), if any within six weeks of the admission of the resident.

During stage 1 of the RQI, interview of the SDM for Resident #22 stated "it was much later after the resident was admitted and I had to call to schedule the six week care conference".

Review of the health record for Resident #22 indicated the resident was admitted and the 6 week care conference was not completed until 9 weeks after admission.

Interview of DOC indicated that she organizes all the care conferences and when she took over the role of DOC, the home was behind on completing care conferences. [s. 27. (1)]

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee failed to respond the Resident's Council in writing within 10 days of receiving concerns or recommendations from the Council

Review of the Residents' Council meeting minutes dated August 28, 2014 was completed. No response to the concern below was noted.

The minutes stated that one resident stated that they were concerned about baths. They said that the bath PSW staff on their unit called in twice in a week. "Sometimes baths are missed or sometimes there aren't enough staff for me to have a bath".

Interview with Administrator was conducted and he stated that he does not remember responding to this concern. [s. 57. (2)]

Issued on this 22nd day of December, 2014

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CHANTAL LAFRENIERE (194), AMANDA NIXON (148), KARYN WOOD (601), LYNDA BROWN (111), MARIA FRANCIS-ALLEN (552)
Inspection No. / No de l'inspection :	2014_365194_0024
Log No. / Registre no:	O-000667-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 17, 2014
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 MCLAUGHLIN ROAD 114 McLaughlin Road, LINDSAY, ON, K9V-6L1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Paul Ludgate

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 :

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

Order / Ordre :

The licensee shall ensure that at least one Registered Nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times

Grounds / Motifs :

1. The staffing schedules for Registered Nurses for the period of September 01, 2014 to November 16, 2014 indicated that 18 (12 hours shifts) and 5 (8hour) shift did not have Registered Nurses on duty and present in the home.

DOC stated that the home has been attempting to recruit for additional Registered Nurses and has not been successful, they have recently received some Registered Nurse applicants and are in the process of interviewing. (194)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Feb 05, 2015

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(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
(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).

Order / Ordre :

The licensee shall prepare, implement and submit a corrective action plan indicating how the licensee shall ensure;
- A Personal Support Worker (PSW) staffing mix that is consistent with resident's assessed care needs related to bathing
- A back-up plan for Personal Support Worker (PSW) staffing that addresses situation when staff cannot come to work as scheduled to ensure that care routines can be maintained, specifically as it pertains to bathing

The plan shall be submitted in writing by fax to Inspector: Chantal Lafreniere at 905-433-3013 on or before December 24, 2014. The plan shall identify the person responsible for each of the corrective actions listed

Grounds / Motifs :

1. Interview with DOC confirmed that one of the home's "bath shift positions " had been vacant for some time. DOC stated that attempts to fill the position had been made but that the home had been unsuccessful. The position is currently filled. A review the PSW staff schedules for the period of September 2014 to

October 2014 was completed, indicating that for the month of September 2014 a total of 26 bath shifts were not staffed and in October 2014 at total of 19 baths shifts were not staffed.

The responsibility of the bath shift position is to provide baths to residents on the unit according to the bath schedule, which enable the unit to provide 2 baths a week to residents.

Interview with PSW # 121 who is the bath person on unit # 2 indicated that she has been pulled from the bath shift position to cover on the unit as a PSW staff if someone calls in sick.

During and interview PSW #117 indicated that when the bath shift person calls in sick and is not replaced baths are not completed on the unit. PSW #117 stated that the bath person called in sick on her unit on November 24, 2014 and was not replaced.

Interviews with Resident's # 41 #45, # 47, # 03, #24 indicated that their baths had not been provided related to staff not being available.

Review of the Resident Council minutes for the month of August 2014 indicated that a concern was brought forward by the Council about baths being missed and the concern that there was not enough staff on the unit to provide the baths.

The DOC has indicated that a back up PSW staffing plan had not been developed or implemented when the bath shift position cannot be staffed on the unit to accommodate residents baths.

The concern of missed baths was found to be widespread an affecting the quality of life and emotional wellbeing of residents in the home. The concern was identified in the Resident Council minutes as well as voiced to inspector during the inspection process by a number of Residents in all areas of the home. The Resident's interviewed were frustrated and upset about the missed baths and indicated that they did not feel there was anything they could do about it.

(194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 05, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

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

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

La demande de réexamen doit contenir ce qui suit :

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

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

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

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

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

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

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

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

Issued on this 17th day of December, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Chantal Lafreniere

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