Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 17, 2018	2018_606563_0001	028903-17	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 WOODSTOCK NURSING HOME
81 FYFE AVENUE WOODSTOCK ON N4S 8Y2

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

MELANIE NORTHEY (563), ADAM CANN (634), AMIE GIBBS-WARD (630)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 2, 3, 4, 5, 8, 9 and 10, 2018

The following intakes were completed within the Resident Quality Inspection:
021438-17 -IL-52780-LO - Complaint related to medication administration
024443-17- 2636-000038-17 - Critical Incident related to suspected staff to resident abuse
016258-17- 2636-000032-17 - Critical Incident related to a fall
029063-17- IL-54618-LO - Complaint related to Infection Prevention and Control Program
026944-17- 2636-000041-17 - Critical Incident related to a fall

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing, the Sienna Operations Specialist, the Resident Care Coordinators, the Resident Assessment Instrument Coordinators, the Food Nutrition Manager, the Public Health Inspector, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Dietary Aides, Cooks, Restorative Aides, Representative of Residents' Council and Family Council, family members and residents.

The inspector(s) also conducted a tour of the home and made observations of residents, activities and care. Relevant policies and procedures, as well as clinical records and plans of care for identified residents were reviewed. Inspector(s) observed meal and snack service, medication administration and drug storage areas, resident and staff interactions, infection prevention and control practices, the posting of Ministry information and inspection reports and the general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **6 WN(s)**
- **5 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. 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.

Review of the Critical Incident System Report where a resident had a documented incident with an injury.

Review of the current care plan in Point Click Care (PCC) documented that the resident has multiple interventions in place related to safety.

The resident was observed without a specific intervention in place as specified in the plan of care.

A Personal Support Worker (PSW) verified that the resident did not have the specific intervention in place and the PSW had worked in the resident's home care area for the last 6 years and did not recall the intervention ever being used by the resident.

The Director of Nursing (DON) shared that there was follow up with the staff and the resident was to use the intervention as described in the care plan in PCC. The DON acknowledged that the staff did not implement the intervention.

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. [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 to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: 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 where the Act or this Regulation required the licensee of a long-term care home to have, instituted or otherwise put in place any plan, policy, protocol, procedure, strategy or system; the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system was complied with.

Ontario Regulation 79/10 s. 30 (1) states, "Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required."

Section 11 (1)(a) of the Long Term Care Homes Act, 2007 states, "Every licensee of a long-term care home shall ensure that there is an organized program of nutrition care and dietary services for the home to meet the daily nutrition need of the residents."

Ontario Regulation 79/10 s. 68 (1)(a) states, "This section and section 69 to 78 apply to (a) the organized program of nutrition care and dietary services required under clause 11 (1)(a) of the Act."

Ontario Regulation 79/10 s. 68 (2)(a)(b)(c) states, " Every licensee of a long-term care home shall ensure that the programs include (a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutritional care and dietary services and hydration; (b)

the identification of any risks related to nutritional care and dietary services and hydration; (c) the implementation of interventions to mitigate and manage those risks."

The Resident Care Coordinator (RCC) told the Inspector that they had been notified by a Public Health Inspector regarding potential concerns with food preparation.

The Food and Nutrition Manager (FNM) said that they had been contacted by a Public Health Inspector. They said that the Public Health Inspector indicated that they wanted a copy of the menu and then requested samples of the menu items for testing. The FNM said the Public Health Inspector sent them an email requesting that they save the food samples for a specific time frame. The FNM said that at that time the samples were being kept in the second floor freezer and the FNM personally went up and saw the samples and left a note for staff requesting that they do not throw them out. The FNM said an unknown staff member had thrown out the samples and the samples could not be provided to the Public Health Inspector. The FNM said that as part of their food production system policies they do have a policy regarding food samples. The FNM said that this policy directed that staff were to store samples in the freezer for ten days and the staff in the home did not comply with this policy regarding these requested samples.

Two Cooks told the Inspector that there was a procedure in the home for keeping food samples of the menu items as part of the food safety practices. The Cooks said that the practice was that food samples were saved and kept in the freezer but they were unsure how long the samples were to be kept, but thought that the food samples were to be kept for seven days before they could be thrown away.

The home's policy titled "Food Production – Safety and Sanitation Food Samples" effective September 2013, stated, "Food Samples are taken to provide a standardized method of collecting samples of hazardous foods form each meal. This method will ensure that the laboratory would receive samples of adequate quality and quantity in the event of a food-borne disease outbreak." The procedures in this policy stated, "the sample will then be stored under freezer conditions for a period of ten days, then discarded by the cook/designate if not needed for outbreak analysis."

The Public Health Inspector told the Inspector that they had been involved regarding potential concerns with food preparation. The Public Health Inspector said that they requested temperature logs and the menu from the Nutrition Manager in the home and then they requested food samples to be kept. The Public Health Inspector said that when they went to the home to pick up the samples for testing, they were not available as a

staff member had thrown them out.

Based on these interviews and a review of the home's policy "Food Production – Safety and Sanitation Food Samples", which was part of the organized program of nutrition care and dietary services in the home, the licensee failed to ensure that this policy was complied with. [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 where the Act or this Regulation required the licensee of a long-term care home to have, instituted 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 is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be kept closed and locked.

An initial tour of the home was completed during the Resident Quality Inspection by two Inspectors.

A door on the main floor at the rear of the main floor and leading to the outside of the home was observed to be unlocked. A keypad code to keep the door locked was located next to the door and the light was green on the keypad indicating the door was not locked.

The Administrator stated that the door was a delivery door and should have been kept locked if the door was not being used for deliveries. The Administrator verified that residents would be able access the delivery door leading to the outside of the home and stated that at the time of the observation, no deliveries were being made and the door should have been locked.

The licensee has failed to ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be kept closed and locked. [s. 9. (1) 1. i.]

2. The licensee has failed to ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

An initial tour of the home was completed during the Resident Quality Inspection by two Inspectors.

On the first floor in the South wing, a clean utility room across from the medical storage room by the hair salon was found to be unlocked. The room had chemicals inside including Virox and Hydrogen Peroxide wipes. A Personal Support Worker (PSW) stated that the clean utility was to be kept locked at all times as it was a non-residential area that contained chemicals.

The first floor, janitor room "A 135" was observed to be unlocked. The room had a dispenser for "UC22" which was a heavy duty neutral floor cleaner.

On second floor, room "A 238" was observed to be unlocked with chemicals including Oxivir Surface Cleaner, Virox Prevention Cleaner, and Glance Diversey. The Resident Assessment Instrument Coordinator stated that the door to "A 238" should have been kept locked as it was a non-residential area with chemicals inside.

The Sienna Operations Specialist (SOS) stated that the older model of coded button door locks were not functioning properly in the home. The SOS stated that when the doors shut, they were to lock instantly and they were not and stated that maintenance staff were checking all doors and a plan to replace the locks was implemented.

The licensee has failed to ensure that all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. [s. 9. (1) 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 all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be kept closed and locked, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident had fallen, the resident was assessed and, if required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Review of the Critical Incident System Report where a resident had two documented incidents with an injury.

The "Safety Plan- Resident" policy was last reviewed July 2016. The policy stated that upon discovery of a fall, a Code Care was called and the internal incident report "Post Fall Investigation" was completed. This policy provided instructions for the reader to refer to the policy and procedures for Code Care. The "Code Care: Come, Assess, React, Evaluate" policy was last reviewed July 2016. The Code Care policy stated that the staff members attending to the fall will hold a fall huddle and complete the post fall investigation form. Review of the "Safety Plan – Post Fall Investigation" form documented post fall follow up expectations that included completion of the following documentation:
- Fall progress note,
- Risk Management Report,
- Post Fall Investigation Summary in the progress notes,
- Fall Risk Assessment Tool, and
- Fall prevention Care Plan reviewed.

Review of the "Assessments" tab in Point Click Care (PCC) documented that a "Caressant Care Fall Risk Assessment" was not completed related to the two documented incidents.

The Director of Nursing (DON) verified that there was no "Risk Management" post fall incident assessment completed for the resident and shared that there should also be a Safety Plan - Post fall Investigation done after every fall and this too did not happen after the two incidents. The DON shared that as part of the Safety Plan - Post Fall Investigation, there were mandatory tasks identified and one was to complete a Fall Risk Assessment post fall and this was not done.

The licensee has failed to ensure a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls when the resident had two separate incidents [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident has fallen, the resident is assessed and, if required, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

s. 229. (5) The licensee shall ensure that on every shift,
(b) the symptoms are recorded and that immediate action is taken as required. O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that on every shift, symptoms indicating the presence of infection in residents were monitored and the symptoms were recorded and that immediate action was taken as required.

A) A resident had an infection according to the most recent Annual Minimum Data Set (MDS) Assessment.

Record review of the "Monthly Line Listing" where there was no documentation related to symptom monitoring each shift and there was no documentation identified in the progress notes related to the resident's symptoms.

The Resident Care Coordinator (RCC) acknowledged that there was no documentation in the progress notes every shift related to the infection symptoms for the resident. The RCC verified that the expectation was that symptom monitoring documentation related to symptoms of infection should occur each shift the resident demonstrates symptoms of an infection as stated in the legislation. The Inspector and the RCC reviewed the vitals documented in PCC and the RCC acknowledged that vital sign documentation was absent when the resident was exhibiting signs of an infection.

The RCC stated that they were unaware that the monitoring and documentation of symptoms of infection was to be completed every shift, and thought it was just during an outbreak where symptoms would be documented on the line listing. The RCC shared that an alert has been added to the dashboard in PCC for all staff to review.

The Dashboard Home alerts in PCC posted the following message on January 6, 2018, "According to the Long Term Care Homes Act, with regards to infection control, any resident with symptoms of infection:
The licensee shall ensure that on every shift, (a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and (b) the symptoms are recorded and that immediate action is taken as required." (563)

B) A resident's clinical record was reviewed for an infection which triggered to stage two of a Resident Quality Inspection (RQI) from the Minimum Data Set (MDS) Assessment.

Review of the MDS assessment documented the resident as having an infection. The progress notes did not document symptoms of infection each shift.

The RCC stated that it was the expectation of the staff to document on every shift, the symptoms of infection if a resident was showing signs of an infection. The RCC stated that the documentation would be completed on a line listing if the home was in outbreak and in the progress notes if they were not in outbreak at the time. The RCC stated that at the time the resident had an infection, the home was not in outbreak and there was not a line listing. The RCC stated that the staff members did not complete documentation on every shift in the progress notes related to symptoms of infection as they should have. (634)

The licensee has failed to ensure that on every shift, symptoms indicating the presence

infection for the residents were monitored and the symptoms were recorded. [s. 229. (5)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance failed to ensure that on every shift, symptoms indicating the presence of infection in residents are monitored and the symptoms are recorded and that immediate action is taken as required, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that, as part of the organized program of housekeeping, procedures were developed and implemented for the cleaning and disinfection of devices including personal assistance services devices.

The Inspector observed two residents using personal assistance services devices with dirt and debris observed.

Review of the clinical records showed that both residents used a personal assistance

services device as their primary mode of locomotion. The cleaning of the personal assistance services devices was not included in the plan of care or Point of Care (POC) tasks in Point Click Care (PCC) for either resident.

The Registered Nurse (RN) told the Inspector that resident personal assistance services devices were cleaned on the night shift by Personal Support Workers (PSWs) based on a schedule. The RN said that there was a binder with the "PSW Night Assignment Duties" schedule for cleaning and the staff did not sign off anywhere if this had been completed. The RN said the "PSW Night Assignment Duties" showed that the residents were scheduled to have their personal assistance services devices cleaned once every two weeks. The RN and the Inspector observed the residents' devices and the RN acknowledged that they were not clean.

The Director of Nursing (DON) observed the residents' personal assistance services devices with the Inspector and acknowledged that they were not clean. The DON said it looked like dirt build up that had taken place "over more than a week". The DON said that there was a process in the home for cleaning personal assistance services devices which was outlined in the home's policy titled "Commodes, Wheelchairs, Lifts – Cleaning Guidelines" in combination with the "PSW Night Assignment Duties" schedule. The DON said that the process did not include documentation by staff that the cleaning had been completed.

The home's policy tilted "Commodes, Wheelchairs, Lifts – Cleaning Guidelines" with effective date August 2013, included the following:
-"All equipment will be clean and well maintained."
-"All wheelchairs, walkers, gerichairs, commodes, lifts and shower chairs are to be cleaned daily by the PSW's."

The DON told the Inspector that it was the expectation in the home that personal assistance services devices would be kept clean as per the home's policy and acknowledged that the procedures were not implemented for the cleaning and disinfection of personal assistance services devices to ensure that the residents' devices were kept clean.

The licensee has failed to ensure that, as part of the organized program of housekeeping, procedures were developed and implemented for the cleaning and disinfection of devices including personal assistance services devices. [s. 87. (2) (b)]

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Issued on this 5th day of February, 2018

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

Original report signed by the inspector.