Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

Rapport d'inspection prévue 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 Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 11, 2019	2019_778563_0032	008896-19, 009398-19, 009401-19, 014924-19	Follow up

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), AMIE GIBBS-WARD (630), CHRISTINA LEGOUFFE (730), MEAGAN MCGREGOR (721), RHONDA KUKOLY (213)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): September 10, 11, 12, 16, 17, 18, 19, 20, 23, 24 and 26, 2019

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Nursing, the Assistant Director of Nursing, the OMNI Clinical Operations Manager, the OMNI Lead, a Resident Care Coordinator, the Behavioural Supports Ontario (BSO) Registered Practical Nurse, the BSO Personal Support Worker, Registered Nurses, Registered Practical Nurses, Personal Support Workers and residents.

The inspector(s) also made observations of residents and care provided. Relevant policies, procedures, program evaluations were reviewed, as well as clinical records and plans of care for identified residents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Pain
Personal Support Services
Responsive Behaviours
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 VPC(s)**
- **0 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
O.Reg 79/10 s. 31. (3)	CO #004	2019_722630_0005	630
O.Reg 79/10 s. 52. (2)	CO #006	2019_722630_0005	213
O.Reg 79/10 s. 53. (3)	CO #001	2019_722630_0006	563
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2019_722630_0016	730

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	Légende 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. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

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

A follow up inspection was completed related to Compliance Order #006, issued in inspection #2019_722630_0005, related to the pain management program.

A record review for the resident was completed and progress notes in Point Click Care (PCC) showed that the resident returned from an appointment and was transferred via mechanical lift. The resident was brought to the nursing station with complaints of pain. The resident was transferred to hospital for assessment at the resident's request. Later that day, Woodstock Hospital advised the home that the resident was returning with an injury.

The care plan in PCC for the resident documented a focus related to pain and transfers.

The electronic Medication Administration Record (eMAR) showed the resident had a physician's order for pain medications as needed. The eMAR showed that the resident received this pain medication on 48 occasions over 19 days, including four times over two days, and five times in one day. The resident did not have a regular dose of pain medication ordered and the previous regularly scheduled dose of pain medication was discontinued.

The Assistant Director of Nursing (ADON) said the resident suffered an injury. The ADON said the expectation was that the resident should have been reassessed and the plan of care reviewed and revised when the resident suffered the injury related to care, transfers and pain. The ADOC also said that the resident's medications should have been reassessed and revised due to the increased us of the as needed (PRN) pain medications.

The OMNI Clinical Operations Manager (OCOM) said the resident should have been reassessed and the plan of care reviewed and revised when the resident suffered the injury. They also said the resident's medications should have been reassessed and revised due to the amount of PRN pain medications utilized.

The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed due to an injury, and with significant use of PRN pain medication. [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 the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that at least one registered nurse, who was both an employee of the licensee and a member of the regular nursing staff of the home, was on duty and present in the home at all times.

During the evening shift, Inspectors were conducting observations throughout the home and noted that only one Registered Nurse (RN), who was from a staffing agency, was working in the home at that time. The Agency RN working on the first floor in Section A of the home stated they were not sure if there were any other RNs working in the home at that time. The Agency RN stated that both registered staff members working in Section B of the home were from an agency and that the Registered Practical Nurse (RPN) working on the second floor in Section A was the only member of the regular nursing staff working at that time. The RPN said the only RN in the home at that time was the Agency RN.

The Executive Director (ED) stated the home's expectation was to always have one of their registered staff members in the building on the evening and night shifts and that the RN working on evening or night shift must be a member of the regular nursing staff of the home. The ED stated there had been times where the only RN working in the home was from a staffing agency.

The ED provided Inspectors with "Caressant Care Nursing Home Staff Assignment Sheets" which indicated the planned staffing level in the home was two RNs on the evening shift and one RN on the night shift. There was no RN working who was a member of the regular nursing staff of the home for 15 shifts over several weeks.

The Inspector and the ED reviewed the "Caressant Care Nursing Home Staff Assignment Sheets". The ED stated they were aware there was no RN working in the home that was a regular staff member of the home for 15 shifts over several weeks. The ED further stated there was a registered staff member of the home in the building, just not an RN.

The licensee has failed to ensure that at least one registered nurse, who was both an employee of the licensee and a member of the regular nursing staff of the home, was on duty and present in the home on 15 identified shifts. [s. 8. (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 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, 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. (2) The licensee shall ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. O. Reg. 363/11, s. 1 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure there was a written policy that dealt with when the doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

The Inspector observed first floor Section A of the home and heard an alarm sound from the door leading to the patio at the end of the hallway across from the staircase. A resident and visitor were observed sitting on the patio at this time. A Personal Support Worker (PSW) came to the patio door and disarmed the alarm for the door. After disarming the alarm, the PSW stuck their head out the door and asked if the resident and visitor needed anything and then proceeded to walk down the hallway away from the patio door. The Inspector was able to push the door to the patio open without an alarm sounding. The resident and their visitor were sitting on the patio and no staff members were observed to be present in the area at that time.

The Registered Nurse (RN) said the patio door at the end of the hallway on first floor of Section A was open and disarmed during the day because of the nice weather and was locked and armed at night around 2100 hours. The RN considered this to be a secure area.

The Executive Director (ED) stated the doors leading to the patios and balconies on the first and second floors did not need to be locked because they were secure areas. The ED provided the Inspector with a policy titled “Call Bell and Door Alarm" with a review date of February 2018. The policy did not identify when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. The ED stated they could not find any written policy that dealt with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents as requested.

The licensee failed to ensure there was a written policy that dealt with when the doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. [s. 9. (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 there is a written policy that deals with when the doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Findings/Faits saillants :

1. 1. The licensee has failed to comply with Compliance Order (CO) #001 from Follow Up inspection #2019_722630_0016 served on July 29, 2019 with a compliance due date of August 31, 2019.

The licensee was to be compliant with s. 6 (7) of the LTCHA. Specifically, the licensee was to:
"a) Ensure that the care set out in the plan of care related to grooming/hygiene and falls prevention is provided to a resident.
b) Ensure that the care set out in the plan of care related to mobility, transfers and falls prevention is provided to three residents and any other resident in the home, as specified in their plan.
c) Ensure that as part of the Falls Prevention and Management program an auditing process is developed and fully implemented to ensure that the plan of care for residents at moderate or high risk for falls are provided to the residents
as specified in their plans. This auditing process must include a regular schedule for

audits. The home must maintain documentation of the audits which is to include the auditing schedule, the names of the people conducting the audit, the residents who have been audited, the results of the audit and what actions were taken in regards to the audit results.
d) As part of the Falls Committee "falls tracking" activities in the home, post-fall assessments will be reviewed to determine if, at the time of the fall, the care set out in the plan of care had been provided to the resident as specified in their plan. This review and tracking will be documented as part of the Falls Committee meeting minutes."

The licensee completed part a) and b).

The licensee failed to complete part c) and d).

The Resident Care Coordinator (RCC), who was identified as the Falls Program lead in the home, said they were familiar with Compliance Order (CO) #001 from inspection #2019_722630_0016 related to plan of care. The RCC said that they were conducting audits of fall prevention interventions and would run the "Care Plan Item/Task Listing Report" in Point Click Care (PCC) for a specified home area. The RCC said they went through the list of residents on a home area who used either a fall mat or a bed and/or chair alarm and included each of those residents in the audit.

The RCC provided the Inspector with a document titled, “Falls Intervention Checklist and Equipment Monitoring” which they said was the tool they used to conduct the audits. The RCC said that they chose a different home area each month to audit. The RCC said they did not have documentation of the schedule of the audits. The RCC stated the “Falls Intervention Checklist and Equipment Monitoring” for July did not include the name of the person who completed the audit. The RCC said they would enter a progress note for that resident in PCC or they would document the results of the audit and the actions taken related to the audit results in the comments section of the auditing document.

The “Falls Intervention Checklist and Equipment Monitoring" dated July 2019 documented the home area as “Level.” The document included the following headings: resident, risk of falls, falls interventions in place, bed alarm checked and in working condition, care plan reviewed, and comments. For the July 2019 audit, there was no documentation on the auditing tool for the actions taken as a result of the audit. There was no documentation of the name of the person who completed the review or the specific date of the review. The RCC did not provide the Inspector with documentation of the auditing schedule. There was no audit for August, 2019 provided.

The RCC stated two residents who were at high risk for falls and two residents who were at medium risk for falls were reviewed at the monthly Falls Committee meeting. The RCC said they would obtain the names of residents who were at high or moderate risk for falls by running a report in PCC for the Morse Fall Scale risk score. The meeting minutes did not document whether the plan of care was provided to the residents as specified in their plan for those residents at moderate or high risk.

The RCC said that they also conducted an audit called the "Resident Safety Plan Audit" for any resident who had a fall. The "Resident Safety Plan Audit" did not document whether the plan of care for residents at moderate or high risk was provided to the residents as specified in their plan. The RCC said that they were not familiar with part d) of CO #001 and said they reviewed the Post Falls Assessments daily; but the Falls Committee meetings had a set agenda and a review of the post falls assessments was not currently included in the agenda or documented in the meeting minutes.

The OMNI Lead said that the RCC was the individual in the home who was taking the lead on CO #001. They said they were not familiar with part d) of the CO #001. The OMNI Lead referred to their copy of the home's "Action Plan" dated July 2019 and CO #001 did not correctly document CO #001 and the action plan indicated an incorrect compliance due date.

The OMNI Clinical Lead said for part d) of the order a review of the post- fall assessments was not currently included in the Falls Committee meetings.

The licensee did not comply with Compliance Order #001 part c) and d) issued July 29, 2019 in inspection #2019_722630_0016 with a compliance date of August 31, 2019. They did not ensure that an auditing process was developed and fully implemented to ensure the plan of care for residents at moderate or high risk for falls were provided to the residents as specified in their plans. They also did not ensure that as part of the Falls Committee "falls tracking" activities in the home, post-fall assessments were reviewed to determine if, at the time of the fall, the care set out in the plan of care had bee provided to the resident as specified in their plan. The tracking was not documented as part of the Falls Committee meeting minutes. [s. 101. (3)]

Issued on this 21st day of October, 2019

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

Original report signed by the inspector.