Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 26, 2020	2020_778563_0034	019658-20	Complaint

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)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 16, 17, 18 and 19, 2020

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Resident Assessment Instrument (RAI) Coordinator, the Registered Nurse/Wound Lead, the Behavioural Supports Ontario Registered Practical Nurse, the Public Health Nurse, Personal Support Workers, the Environmental Services Manager, a Maintenance Member, one family member and residents.

Inspector(s) also made observations of residents, care and infection prevention and control practices. Relevant policies and procedures, as well as, documentation reports, clinical records and plans of care for identified residents were reviewed.

The following Inspection Protocols were used during this inspection:
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **2 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	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. (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).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for two residents set out clear directions to staff who provided direct bathing care to the residents.

Due to COVID-19 Infection Prevention and Control (IPAC) safety precautions that had been implemented in the home for bathing care for approximately six months. A resident's plan of care identified their preferred method for care was to be bathed in the tub and it did not include direction for staff regarding their individual care requirements for showers or bed baths. Staff reported that the resident required the use of specific assistive device to support their safety during care and this was not included in their care plan or kardex. The Resident Assessment Instrument (RAI) Coordinator reported that when the bathing care changed in the home due to COVID-19 the care plans were not revised. They said this was so the staff would still know the resident's preferences and care needs. The lack of clear directions for their bathing care during this time placed the resident at risk for injury and for not consistently receiving the interventions they required.

Another resident's plan of care stated they required physical help for transfers only for their bathing routine with no clear direction for staff regarding the resident's individual care requirements. The resident was assessed as requiring total assistance with two staff. The Director of Care stated the resident required more support for their bathing routine than just help with transfers. The lack of clear direction for during this time placed the resident at risk for injury and for not consistently receiving the and staffing support they required or the interventions related to self performance.

Sources: Residents' clinical records including care plans; interview with a resident, the Director of Care, RAI Coordinator and other staff. [s. 6. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: 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 eight residents were bathed, at a minimum, twice a week by the method of their choice.

Staff had been showering or providing bed baths to the residents as it was their understanding that the whirlpool tubs in the home were not available to be used due to COVID-19 Infection Prevention and Control (IPAC) safety precautions. The restriction on the use of the whirlpool tubs for bathing related to COVID-19 and the method for bathing was not re-evaluated by the home based on evidence based or prevailing practices. The Public Health Nurse stated there had been no specific identification of increased risk with using the whirlpool tubs during COVID-19.

A complaint was submitted to the Ministry of Long-Term Care by a family member of a resident related to the home’s decision to stop using the whirlpool tubs due to COVID-19. The resident had a bed bath for approximately five months. The complainant reported that the resident was normally a tub bath according to the plan of care and the resident’s scalp was red, hair was dry and there was body odour from a lack of appropriate bathing during this time. Progress notes identified the resident had a shower on the insistence of their family member.

Eight residents had a preferred method for care that was to be bathed in the tub. Residents did not receive tub baths for approximately six months. Three residents reported they were told by staff that the tub was broken and unavailable for use. A Personal Support Worker (PSW) stated residents requested a bath on multiple occasions but were denied. The residents were not harmed related to the provision of showers or bed baths instead of tub baths, but their bathing preference was not fully respected by the home and were at increased risk of refusing their bathing care during this time. One resident was admitted to the home during COVID-19 and the resident stated they were not offered a tub bath as a choice for bathing. The RAI Coordinator stated preferences were discussed on admission, but that a shower would be provided during COVID-19.

Sources: Complaint Information Report, residents' clinical records including care plans, Caressant Care Woodstock Follow Up Question Reports; and interviews with the complainant, the Director of Care, the RAI Coordinator, BSO PSW and other staff. [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 to ensure that the resident is bathed, at a minimum, twice a week by the method of his or her choice, including tub baths, showers, and full body sponge baths, and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

Issued on this 30th day of November, 2020

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

Original report signed by the inspector.