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

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

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 public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Jul 16, 2015	2015_416515_0018	015238-15	Resident Quality Inspection

Licensee/Titulaire de permis

CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE WOODSTOCK ON N4S 3V9

Long-Term Care Home/Foyer de soins de longue durée

CARESSANT CARE COURTLAND
4850 Hwy #59 P.O. Box 279 Courtland ON N0J 1E0

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

RAE MARTIN (515), HELENE DESABRAIS (615), NANCY JOHNSON (538)

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): July 2, 3, 6, 7, 8, 9, 10 and 13, 2015.

Critical Incident 2826-000005-15, Log #003492-15 and Critical Incident 2826-000013-15, Log #011523-15 both related to abuse of residents were inspected concurrently.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing, Regional Manager, Environmental Services Consultant, Activation Manager, Nutritional Manager, Maintenance Supervisor, RAI Coordinator, two Registered Nurses (RN), three Registered Practical Nurses (RPN), seven Personal Support Workers (PSW), two Housekeeping Liaisons, a Laundry Liaison, a Restorative Care Aide, a Physiotherapy Assistant (PTA), 40+ residents and three family members.

The Inspector(s) also toured all resident home areas and common areas, observed residents and the care provided to them, resident-staff interactions, recreational activities, dining service, medication administration, medication storage areas, laundry room, posting of required information, general maintenance, cleanliness and condition of the home. Health care records and plans of care for identified residents were reviewed, as well as the home's internal investigation notes, staffing schedules and relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
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
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **4 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. 17. (1)	CO #001	2014_277538_0032	538

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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 any plan, policy, protocol, procedure, strategy or system put in place is complied with.

An interview with the Substitute Decision Maker (SDM) for an identified resident revealed that the resident was missing a personal belonging. The SDM shared that upon inquiring about the missing personal belonging, the Administrator located it and discovered that it was broken.

A record review revealed there was no documented evidence of the identified resident's missing personal belonging.

A review of the home's policy entitled Residents' Personal Belongings, dated February 2013, indicated that "If something belonging to a resident does get broken, report it to the Administrator immediately. The management of the home will notify the resident and/or their family."

The Administrator confirmed that the home did not comply with their policy by not notifying the Administrator when the personal belonging was broken. [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 any plan, policy, protocol, procedure, strategy or system the licensee is required to have in place is complied with, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

Observations made throughout the RQI revealed:

a) In six identified resident rooms, the ceiling vents above the toilets were visibly soiled with dust.
b) One third to one half of the ceiling tiles in the hallways were visibly soiled with dust and dust was noted to be hanging from the ceiling grid that supports the tiles.
c) Dead insects were observed in 35/45 (78%) of the ceiling lights in the hallways, 8/8 (100%) of ceiling lights in an identified dining room, 4/5 (80%) of the ceiling lights in the TV/library room and 4/5 (80%) of the ceiling lights in the vending machine room. [s. 15. (2) (a)]

2. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a good state of repair.

Observations made throughout the RQI revealed that six residents' bedroom/bathrooms had paint scrapes, peeling paint and holes in the walls requiring repair. Additionally, in common areas of the home, 52 ceiling tiles were stained and three ceiling tiles were ill fitting.

The observations regarding cleanliness and maintenance were verified by the Maintenance Supervisor and the Administrator. They also confirmed the expectation is that the home is to be kept clean and sanitary and in a good state of repair. [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that the home, furnishings and equipment are kept clean and sanitary and in a good state of repair, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A clinical record review for the period of 11 months revealed that an identified resident complained of pain 12 times.

There was no documented evidence that a pain assessment using a clinically appropriate tool for pain was completed for the resident. This observation was confirmed by a Registered Staff member.

The Director of Nursing confirmed that it is an expectation of the home that pain assessments using a clinically approved assessment tool be completed. [s. 52. (2)]

2. An interview with an identified resident revealed the resident had complaints of pain and takes pain medication.

A clinical record review for the period of four months revealed that the resident complained of pain 44 times. A review of a quarterly MDS Assessment indicated the resident had pain symptoms daily with a pain level score of three.

There was no documented evidence of a further pain assessment using a clinically appropriate tool for pain was completed for the resident.

A review of the home's policy entitled Pain Assessment, dated May 2015, indicated residents who score a two (2) or higher on any MDS assessment will have a further pain assessment completed using the Caressant Care Pain Assessment Tool.

An interview with a Registered Nurse revealed that a pain assessment for the resident was not completed. The Regional Manager confirmed that it is an expectation of the home that pain assessments using a clinically approved assessment tool be completed. [s. 52. (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 the resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of maintenance services, that there were schedules in place for routine, preventative and remedial maintenance.

Observations made throughout the RQI revealed that six residents bedroom/bathrooms had paint scrapes, peeling paint and holes in the walls requiring repair. Additionally, in common areas of the home, 52 ceiling tiles were stained and three ceiling tiles were ill fitting.

A review of the Environmental Logs and Audits revealed there was no documented evidence that routine and remedial maintenance schedules were kept for painting and repairs to residents rooms. This observation was confirmed by the Corporate Environmental Services Consultant.

In an interview, the Maintenance Supervisor confirmed that a log and schedule had not been kept of the work/repairs to be done in residents rooms and the expectation is that a schedule of required work/repairs would be kept as part of the organized program of maintenance services. [s. 90. (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 schedules are in place for routine, preventative and remedial maintenance, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 41. Every licensee of a long-term care home shall ensure that each resident of the home has his or her desired bedtime and rest routines supported and individualized to promote comfort, rest and sleep. O. Reg. 79/10, s. 41.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's desired bedtime and rest routine was supported and individualized to promote comfort, rest and sleep.

An interview with an identified resident revealed that the resident would like to sleep in sometimes, but staff want him/her to get up and go to the dining room for breakfast.

An interview with two Personal Support Workers revealed that they would refer to the care plan and kardex for information on resident preferences for when residents like to get up in the morning and go to bed at night.

A review of the care plan revealed there was no documented evidence indicating what the resident's preference was for waking up in the morning.

An interview with the Director of Nursing confirmed the observation and also confirmed the expectation that the resident's desired bedtime and rest routine be supported to promote comfort, rest and sleep. [s. 41.]

2. An interview with another identified resident revealed that staff would not let him/her stay in bed when he/she asked to sleep in later.

An interview with three Personal Support Workers revealed that they would refer to the care plan and kardex for information on resident preferences for getting up in the morning and going to bed at night.

A review of the care plan revealed there was no documented evidence to indicate what the resident's preference was for waking up in the morning. The observation was confirmed by a Registered Staff member.

An interview with the Director of Nursing confirmed the expectation that the resident's desired bedtime and rest routine be supported to promote comfort, rest and sleep. [s. 41.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that snack service times were reviewed by the Residents' Council.

A review of minutes from Residents' Council meetings from January 2015 to May 2015, revealed there was no documented evidence that snack service times were discussed with residents.

In an interview, the Activation Manager acknowledged that snack service times are not discussed with the Residents' Council.

The Administrator confirmed the expectation that snack service times are to be reviewed with the Residents' Council. [s. 73. (1) 2.]

Issued on this 20th day of July, 2015

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

Original report signed by the inspector.