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 # / Registre no	Type of Inspection / Genre d'inspection
Nov 21, Dec 21, 2016	2016_255633_0020	029187-16	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

SHERRI COOK (633), MELANIE NORTHEY (563)

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 7,8,9,10, 2016.

The following intakes were completed within the RQI:

#017959-16, IL-44827-LO- Complaint related to the building structure, wound care and restraints.
#16625-16, IL-44826-LO- Complaint related to restraints and infection control.
#024309-16, IL-46056-LO- Complaint related to a resident fall resulting in injury.
#015985-16, CIS #2826-000015-16- Critical Incident related to a building structure, restraints, infection control and wound care.
#023452-16,16, CIS #2826-000019-16- Critical Incident related to a resident fall resulting in injury.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Nursing, the Environmental Services Supervisor, the Activities Director, a Norfolk County Fire Prevention Officer, three Registered Nurses (RN), a physiotherapist, a Behavioural Support staff, two Health Care Aide's (HCA), one Dietary Aide, six Personal Support Workers (PSW), one cook, one housekeeping and laundry staff member, three family members and over 20 residents.

The inspector(s) also conducted a tour of the home and made observations of residents, activities, resident care and resident/staff interactions. A record review of the clinical records of the identified residents was completed including resident assessments and plans of care. Relevant policies and procedures were reviewed. In addition, Inspector(s) observed medication administration and drug storage areas, infection prevention and control practices, and general maintenance, cleanliness and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Skin and Wound Care

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

- **2 WN(s)**
- **0 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. 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every resident had the right to be treated with courtesy and respect and in a way that fully recognized the resident's individuality and respects the resident's dignity.

An identified resident reported that some Personal Support Workers (PSWs) were rude but that it only happened every once in a while. The resident also stated that there were two or three PSWs with an unwelcomed mannerism. The resident felt this was very disrespectful and did not want to make the PSWs mad because they held too much power.
The resident did not feel treated with courtesy and respect during a care routine and shared that staff did not speak with courtesy when this care was provided. Another

identified resident shared that the PSW staff were sharp sometimes with their tone of voice, but that it did not last long and an identified PSW did not speak to inspectors in a manner that would suggest respect or courtesy several times. The Administrator shared that all staff were expected to treat the residents with courtesy and respect at all times.

The licensee failed to ensure that every resident was treated with courtesy and respect in a way that fully recognized the resident's individuality and respected the resident's dignity. [s. 3. (1) 1.]

2. The licensee failed to ensure that every resident had the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

A medication cart was observed outside the nursing station with a clear plastic bag hung at the side of the medication cart that was filled with many empty medication strip packs. The strip packs documented resident names, medications, and other personal health information (PHI). A Registered Nurse (RN) shared that the clear bag was hung on the side of the medication cart for a full day and was also left in the hall at times unattended with the empty strip packs accessible to anyone who passed by and acknowledged that the storage of empty strip packs on the side of the medication cart did not protect the PHI of the residents.

A second medication cart outside the nursing station was observed with a clear plastic bag filled with many empty medication strip packs. Another RN acknowledged that the clear bag that was left attached to the medication cart were in plain sight and did not protect the PHI of the residents and that anyone would have access to this information if they wanted it. The Administrator agreed that the process for storing medication strip packs in a clear plastic bag at the side of the medication cart did not protect the PHI of the residents who received medications throughout the course of the day.

The licensee failed to ensure that every resident had the right to have his or her personal health information kept confidential in accordance with the Act. [s. 3. (1) 11. iv.]

WN #2: 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 or care set out in the plan was no longer necessary.

Record review of the current care plan documented that an identified resident had a specific behaviour related to their diagnosis and the plan of care identified an intervention related to this behaviour.

The Physiotherapy Assistant (PTA) shared that the identified behaviour was no longer exhibited by the resident and this was no longer part of the plan of care. Registered Nurse (RN) shared that the identified resident no longer exhibited the behaviour and the specific intervention was no longer used. RN #112 also shared that the intervention should have been removed from the care plan when the intervention was no longer used.

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 when the care set out in the plan was no longer necessary. [s. 6. (10) (b)]

Issued on this 29th day of December, 2016

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

Original report signed by the inspector.