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

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 # / No de registre	Type of Inspection / Genre d'inspection
Jan 8, 2018	2017_707634_0021	026881-17	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 COURTLAND
4850 Hwy #59 P.O. Box 279 Courtland ON N0J 1E0

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

ADAM CANN (634), MELANIE NORTHEY (563)

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): December 4, 5, 6, 7 and 8, 2017.

The following follow up and intakes were completed at the time of the RQI:

Log #026978-16, CIS #2826-000020-16, related to falls.
Log #011250-17, CIS #2826-000021-17, related to falls.
Log #032539-16, CIS #2826-000027-16, related to alleged visitor to resident abuse.
Log #002549-17, CIS #2826-000008-17, related to alleged staff to resident abuse.
Log #011186-17, CIS #2826-000020-17, related to missing controlled substances.

During the course of the inspection, the inspector(s) spoke with the Director of Care, the Administrator, the Resident Assessment Instrument Coordinator, the Environmental Supervisor, the Activity Director, three Registered Nurses, two Registered Practical Nurses, four Personal Support Workers, one housekeeping staff member, the Residents' Council Representative, 20 residents and three family members.

The inspector (s) conducted a tour of the home, reviewed clinical records, and plans of care for relevant residents, pertinent policies and procedures, Residents Council minutes, and the staff schedule. Observations were also made of general maintenance, cleanliness, and condition of the home, infection prevention and control practices, provision of care, staff to resident interactions, medication administration, and Ministry of Health and Long Term Care postings.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council

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

- **3 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. 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 failed to ensure that there was a written plan of care for each resident that sets out the planned care for the resident.

Review of Critical Incident System (CIS) Reports documented a resident had a fall on two occasions where a head injury was sustained.

Review of the resident's current care plan in Point Click Care (PCC) documented a focus statement related to mobility, transfers and risk of falls. There was no planned care documented related to the use of a specific device.

Review of the Kardex in PCC stated, "Locomotion On Unit" with no other instructions for PSW to follow related to the use of the device.

Review of the Minimum Data Set (MDS) Quarterly Assessment, documented that the device was the resident's primary mode of locomotion.

In interviews with Personal Support Workers, they shared that the resident required total assistance for locomotion in their device.

In an interview with a Registered Nurse (RN), they verified that there was no written plan of care for the resident that set out the planned care for the use of the device for all of their locomotion.

The licensee failed to ensure that there was a written plan of care for resident that sets out the planned care for the use of the device for all locomotion off and on the unit.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that a personal assistive services device that limited the freedom of movement which was used to assist a resident with a routine activity of living was included in the residents' plan of care.

During stage one of a Resident Quality Inspection (RQI), a resident was observed to have a specific assistive device.

In an interview with a Personal Support Worker (PSW), they stated that if a resident used a device, it would be included on the resident's Kardex in Point Click Care. The PSW checked the Kardex and stated that the assistive device was not included on the Kardex for the resident.

In an interview with another PSW, they stated that the resident does have a device which had just been implemented approximately one week ago. The PSW stated that the device should be included in the residents plan of care.

In an interview with Resident Assessment Instrument Coordinator (RAI-C), they stated that the device was not included in the resident's plan of care and should have been included.

Review of the home's policy on Personal Assistive Services Devices (PASD), stated that for PASD's which limited movement where the resident was not cognitively or physically able to remove the PASD, it "shall have this documented in the Plan of Care".

In an interview with Director of Care (DOC) they stated that the device was being used as a PASD and should have been included in resident's plan of care.

The licensee has failed to ensure that a personal assistive services device that limited the freedom of movement which was used to assist a resident with a routine activity of living was included in the resident's plan of care.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 88. Pest control

Specifically failed to comply with the following:

s. 88. (2) The licensee shall ensure that immediate action is taken to deal with pests. O. Reg. 79/10, s. 88 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that immediate action was taken to deal with pests.

On two occasions during the day, inspectors heard movement above the drop ceiling. It sounded like an animal running along the drop ceiling tiles.

In an interview with the Resident Assessment Instrument Coordinator, they shared that their office was beside the Activity Director office and they shared the same drop ceiling. The RAI-C replied that they had heard animal movement along the ceiling tiles and that it was reported the Administrator.

In an interview with the Administrator, they acknowledged that this was a problem and that the Environmental Supervisor was aware. The Administrator shared that animals find their way in at this time of year and that this problem was not new.

In an interview with Environmental Supervisor (ES), they shared that they documented the reported incident of possible pest presence in the pest control book two weeks ago. The ES stated that they looked for entry points around the perimeter of the home and found a hole in the overhang outside of a room. The ES shared that they use a licensed pest controller, but that they were not called, there were no traps in place and the exterior hole in the overhang was not covered. The pest control company had scheduled monthly visits in the home and the next scheduled visit would be in approximately two weeks. The ES was waiting until the next monthly visit to discuss the animal running around in the ceiling.

In a separate interview, the ES stated that a trap had now been set and the hole on the exterior fascia had been covered. The Environmental Supervisor acknowledged that immediate action was not taken to deal with pests. The pest had continued access in the ceiling of the home for at least a month.

The licensee failed to ensure that immediate action was taken to deal with pests in the home.

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.