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

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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
Jan 17, 2020	2020_788721_0002	023689-19, 024169-19	Critical Incident System

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

MEAGAN MCGREGOR (721)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 8, 9 and 13, 2020.

The following Critical Incident (CI) intakes were completed within this inspection:

Log #023689-19/CI #2826-000019-19 related to an incident which caused an injury and where the resident was taken to hospital; and
Log #024169-19/CI #2826-000020-19 related to an incident which caused an injury and where the resident was taken to hospital.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Care, the Environmental Services Supervisor, a Registered Nurse, two Personal Support Workers and residents.

The Inspector also observed residents and the care provided to them and equipment in the home, reviewed clinical records and plans of care for the identified residents and reviewed the home's investigation notes, policies and maintenance records relevant to the incidents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Hospitalization and Change in Condition

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

- **1 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	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 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 where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, protocol or procedure, the policy, protocol, or procedure was complied with.

In accordance with Ontario Regulation 79/10 s. 48 the licensee was required to ensure that a skin and wound program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

Specifically, staff did not comply with the licensee's policy titled "Head to Toe Assessment Form" which was part of the licensee's skin and wound program.

On a specific date, the home submitted a Critical Incident System (CIS) report to the MLTC related to an incident where resident #001 had sustained a specific injury and was transferred to hospital for further assessment. As per the CIS report, resident #001 returned from hospital with specific wound care interventions in place.

A review of Caressant Care Nursing & Retirement Homes Ltd. policy titled "Head to Toe Assessment Form", with an effective date of October, 2018, stated that "upon admission to the facility and upon return to the facility from hospital or leave of absence for longer than 24 hours, a complete head to toe assessment of the resident shall be completed by the registered staff on duty, describing any areas of broken skin, bruising, rashes or other abnormalities".

A review of resident #001's Progress Notes in PointClickCare (PCC) showed documentation from a specific date and time which stated that they had sustained a specific injury and were being sent to hospital via ambulance to assess whether further

intervention was required. A note from a specific time on this same date stated that the hospital was contacted and informed that resident #001 had received a specific treatment related to the injury sustained. Another note from a specific time on this same date stated that resident #001 was returned to the home at a specific time with specific wound care interventions in place.

During an interview on a specific date, when asked what the home's process was for assessing a resident when they returned from hospital, Registered Nurse (RN) #103 stated they would complete a head to toe assessment when a resident returned from hospital after an overnight stay or having received treatment. RN #103 said that head to toe assessments were documented under the Assessments section in PCC. When asked if a head to toe assessment would be completed when a resident went to hospital and returned the same day after receiving the specific treatment that resident #001 had received, RN #103 stated yes.

A review of resident #001's Assessments section in PCC and physical chart did not show any completed head to toe assessments after they returned from hospital on the identified date.

During an interview on a specific date, Director of Care (DOC) #101 reviewed resident #001's clinical record with Inspector #721. When asked what staff were expected to do when a resident returned from hospital, DOC #101 stated if a resident was gone more than 24 hours staff would be expected to complete a head to toe assessment. When asked if there were any head to toe assessments completed when resident #001 returned from hospital on the identified date, DOC #101 stated resident #001 wouldn't have had a head to toe assessment because they weren't gone long enough.

During a telephone conversation on a specific date, Executive Director (ED) #100 and Inspector #721 reviewed the home's policy titled "Head to Toe Assessment Form" with an effective date of October, 2018. ED #100 said they understood the section of this policy which stated "upon admission to the facility and upon return to the facility from hospital or leave of absence for longer than 24 hours, a complete head to toe assessment of the resident shall be completed" to mean a head to toe assessment needed to be completed only if the resident was in hospital for longer than 24 hours.

The licensee has failed to ensure that the licensee's "Head to Toe Assessment Form" policy was complied with when resident #001 did not have a head to toe assessment completed upon their return from hospital on a specific date. [s. 8. (1)]

Issued on this 17th day of January, 2020

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

Original report signed by the inspector.