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
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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
Dec 22, 2015	2015_271532_0034	032447-15	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

CAMBRIDGE COUNTRY MANOR
3680 SPEEDSVILLE ROAD R R 31 CAMBRIDGE ON N3H 4R6

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

NUZHAT UDDIN (532), AMIE GIBBS-WARD (630), DOROTHY GINTHER (568), SHARON PERRY (155)

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): December 8, 9, 10, 11, 15, 16, 2015.

A critical incident inspection Log #016250-15/CI # 2651-000007-15 related to falls was completed concurrently during the Resident Quality Inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Resident Assessment Instrument (RAI) Coordinator, Associate Director of Care, Environmental Services Manager, Director of Recreation, Food and Nutritional Manager, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Staffing Clerk, Dietary Aide and Housekeeping staff, residents and family members.

The inspector also toured the resident home areas, reviewed clinical records, observed the provision of care and interaction between staff and residents, reviewed relevant policies and procedures, reviewed educational records, general maintenance of the home, and resident communication system, medication storage areas, and reviewed medication records as well as meeting minutes pertaining to the inspection.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Reporting and Complaints
Residents' Council
Responsive Behaviours

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

3 WN(s)
1 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 O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff monitored symptoms of infection in residents on every shift in accordance with evidence-based practices, and, if there were none, in accordance with prevailing practices.

Clinical record review revealed that an identified resident was noted to have a change in condition. The physician was contacted and orders were received for a treatment.

Documentation review indicated that there was no further documentation of monitoring of the identified resident's condition and symptoms.

Staff interview with the Director of Care #101 revealed that the staff were to monitor symptoms of infection in residents every shift and then document relevant findings. The staff member shared that the monitoring would continue until symptoms of infection had resolved. The Director of Care acknowledged that the identified resident continued to exhibit a change in condition however, there was no monitoring each shift according to the home's practice.

The licensee failed to ensure that staff monitored symptoms of infection in residents on every shift in accordance with the home's practices. [s. 229. (5) (a)]

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 staff monitor symptoms of infection in residents on every shift in accordance with evidence-based practices, and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 13. Every licensee of a long-term care home shall ensure that every resident bedroom occupied by more than one resident has sufficient privacy curtains to provide privacy. O. Reg. 79/10, s. 13.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident bedroom occupied by more than one resident had sufficient privacy curtains to provide privacy.

During stage 1 of the Resident Quality Inspection the privacy curtains for the identified residents, in ward and semi-private rooms, were found not to be sufficient to ensure privacy.

During an interview with the Director of Care (DOC) #101 revealed that in the ward and semi-private rooms residents should have privacy curtains that completely surround the bed to ensure there was privacy when staff provide care.

During a tour of the home, the DOC confirmed that the privacy curtains for the identified residents were not sufficient to provide privacy.

The licensee failed to ensure that each resident bedroom occupied by more than one resident had sufficient privacy curtains to ensure privacy. [s. 13.]

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident received individualized personal care, including hygiene care and grooming on a daily basis.

In stage I interview with the family member they indicated that they have to ask the staff to provide grooming for the identified Resident.

Observations revealed that the resident was not well groomed.

Plan of care for the resident under hygiene/grooming indicated that the identified resident was totally dependent and staff were to perform total care of activities every day.

Record review and staff interview with the Registered Nurse (RN) #107 indicated that the resident was to have a bath, however, the identified resident was resistive to care.

A Personal Support Worker #111 in an interview confirmed that the identified resident was resistive to care on identified dates, and they were not able to provide personal care.

Record review with the Associate Director Care #102 revealed that the documentation in Point of Care (POC) was incomplete for one of the identified days and for the other identified date the documentation stated that the resident was not resistive to care.

The Associate Director of Care #102 confirmed that the expectation was to have the personal care including grooming on a daily basis.

The licensee failed to ensure that the resident received individualized personal care, including hygiene care and grooming on a daily basis. [s. 32.]

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Issued on this 22nd day of December, 2015

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

Original report signed by the inspector.