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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## 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 |
|---|---|---|---|
| Sep 27, 2018 | 2018_755728_0006 | 014214-18, 022674-18 | Complaint |

### 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. #1 CAMBRIDGE ON N3H 4R6

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

MARIA MCGILL (728), NUZHAT UDDIN (532), SHERRI COOK (633)

## Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Complaint inspection.**

**This inspection was conducted on the following date(s): September 6, 7, 10, 11, 12, 14, 17, 18, 19, 20, 2018**

**The following intakes were completed as part of this inspection:**
**Log #014214-18 / IL-57476-CW related to alleged neglect and improper care of a resident;**
**Log #022674-18 / IL-59275-CW related to alleged neglect and improper care of a resident**

**During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), the Executive Director (ED), the Assistant Director of Nursing (ADON), the Registered Dietitian (RD), the RAI Coordinator, the Maintenance Supervisor, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), and residents.**

**The following Inspection Protocols were used during this inspection:**
**Continence Care and Bowel Management**
**Dining Observation**
**Nutrition and Hydration**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Safe and Secure Home**
**Snack Observation**

**During the course of this inspection, Non-Compliances were issued.**
- **2 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 30. General requirements**

**Specifically failed to comply with the following:**

**s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).**

**Findings/Faits saillants :**

The licensee failed to ensure that any actions taken with respect to a resident under a

program, including assessments, reassessments, interventions and the resident's responses to interventions, were documented.

A complaint was received alleging neglect, improper care, and concerns related to assessments of a specified resident.

The complaint stated that the resident's call bell was wrapped around the bed rail and the resident was unable to reach it.

A progress note (PN) indicated that there was a request made to check on the specified resident. The RN went in and found that the resident was in bed and the resident said that they were okay and denied pain or distress. A full assessment was done on the resident and vital signs and temperature were checked. The RN was informed that the resident was found to be confused and that their call bell was wrapped around the bed rail and the resident wanted help but they could not reach it.

On a specified date, it was reported that the resident was distraught and the registered staff were approached and asked if the nurse could check the vital signs and assess the resident. The nurse said that they would be in after 15-20 minutes to assess the resident but no nurse came to assess the resident until approximately two hours later after the shift change.

An RPN shared that they asked the resident how they were doing and put the thermometer in the resident’s ear. The RPN did not continue with the vitals. The RPN indicated that they did a late entry in the progress notes section of PointClickCare (PCC) after the DOC instructed them to do a detailed note of that day but they still forgot to chart on the temperature.

The late entry progress note dated on a specified date, stated that the resident was assessed but did not document the temperature or vital signs.

The policy titled “Documentation in Resident Health Record” effective date April 2018, stated that all documentation in the health record will be:
-Current or written as close to the time of the event as possible
-Complete and accurate
-Legible
-Input by person who made the observation or who provided the care treatment/ service
-Input in chronological order

-Identified by date, time, signature and designation of the person documenting

The DOC indicated they spoke to the RPN who acknowledged that they completed an assessment and verbalized her assessment but did not write a progress note. The DOC instructed the RPN to do a late entry. The DOC said the RPN did complete a late entry progress note; however, they did not document the details of the assessment including the vital signs and temperature. The expectation was that when the RPN did an assessment that they documented everything including the vital signs in the resident health record; however, this was not completed. [s. 30. (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 any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions, were documented, to be implemented voluntarily.***

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**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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).**

**Findings/Faits saillants :**

The licensee failed to ensure the plan of care was based on an assessment of the resident and the resident's needs and preferences.

A complaint was received alleging neglect and improper care and assessments of a specified resident.

A record review showed that the resident had multiple diagnoses.

The plan of care under toileting indicated that the resident was to receive a specified type of toileting during a certain time frame.

The plan of care under continence indicated that the resident refused a specified intervention and to note any changes in the amount, frequency, colour, and odour and report any abnormalities to registered staff.

The plan of care did not reference that the resident wore a specified urinary intervention at night.

A PSW shared that the resident had a specified urinary intervention at night. The intervention was only used during the night based on the resident's preference.

An RPN was shown the care plan for the resident and confirmed there was no record of the urinary intervention. It did not clarify which incontinence product the resident needed.

An RPN said the resident would sometimes decline the urinary intervention. The RPN acknowledged that the urinary intervention was not reflected in the care plan and its use should have been based on an assessment of the resident and the resident's needs and preferences. [s. 6. (2)]

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**Issued on this 29th day of October, 2018**

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

**Original report signed by the inspector.**