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
Direction de l'amélioration de la performance et de la conformité

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 # / Registre no	Type of Inspection / Genre d'inspection
Jul 7, 2015	2015_171155_0015	L-002224-15	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

CARESSANT CARE ARTHUR NURSING HOME
215 ELIZA STREET P.O. BOX 700 ARTHUR ON N0G 1A0

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

SHARON PERRY (155), DOROTHY GINTHER (568), REBECCA DEWITTE (521), SHERRI GROULX (519)

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): April 28, 29, 30, May 1, 4, 5, 6, 7, 8 and 11, 2015.

A complaint inspection (log # 003983-15) was conducted concurrently during this inspection.
The following follow-up inspections were conducted concurrently during this inspection:
L-001651-14
L-001652-14
L-001653-14.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Assistant Director of Care, Maintenance Manager, Activity Coordinator, RAI Coordinator, Ward Clerk, Housekeeper, two Registered Nurses, three Registered Practical Nurses, 17 Personal Support Workers, Resident Council representative, four family members and 40+ residents.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 17. (1)	CO #004	2014_226192_0038	155
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2014_226192_0038	155
LTCHA, 2007 S.O. 2007, c.8 s. 8. (3)	CO #002	2014_226192_0038	155

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 has failed to ensure that the plan of care sets out clear directions to staff and others who provide direct care to the resident.

During this inspection resident #016 was observed in bed with bed rails in use.

Staff interview revealed that resident #016 uses bed rails. When the staff member was asked how they know what bed rails are used for a resident they indicated that it was posted above the residents bed. Observation of the posting above resident #016's bed indicates that the resident does use bed rails. Review of the resident's plan of care including the Physiotherapy Assessment, kardex and care plan did not reveal that the resident used bed rails.

Interview with the RAI Coordinator acknowledged that resident #016 does use bed rails and confirmed that the plan of care does not provide clear direction to the staff and others that provide direct care. [s. 6. (1) (c)]

2. The transfer logo above resident #006's bed indicates that the resident needs assistance with transferring.
The care plan for transferring for resident #006 indicates that the goal is to maintain ability to transfer self and the resident needs assistance of one person to transfer.
The care plan for toileting for resident #006 indicates the goal is to maintain ability to toilet self safely and resident requires extensive assistance with one staff member. It also states that most of the time the resident will take self to toilet but when needs assistance will ask.
Resident #006 and two PSWs confirmed in interviews that the resident does not toilet self but requires the assistance of one staff for toileting.
The RPN/RAI Coordinator confirmed that the care plan for resident #006 does not

provide clear direction and that resident #006 does require one person assistance for transfers and toileting. [s. 6. (1) (c)]

3. During this inspection it was noted that resident #026 had bed rails up on their bed. There was a sign above resident #026's bed that indicated that the resident did not use any bed rails.

Upon interview with the resident it was confirmed that they use the bed rails.
Upon interview with the RPN it was confirmed that the sign above resident #026's bed did not provide clear direction to staff and others who provide direct care to the resident as it indicated that no bed rails were used and the resident had bed rails in use. The RPN stated that they were in the process of updating signs that did not display current information. [s. 6. (1) (c)]

4. Review of Pixalere documentation for resident #062 indicated that resident #062 had an area of altered skin integrity. Review of the Treatment Administration Record (TAR) which is part of the plan of care for resident #062 indicated that the area of altered skin integrity was in a different location than documented in the Pixalere documentation.

The RPN-Wound Care Champion and the Assistant Director of Care confirmed that resident #062 did not have an area of altered skin integrity in the location as mentioned in the TAR and confirmed that the TAR did not provide clear direction. [s. 6. (1) (c)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident.

During this inspection resident #001, #011, #016, #026 and #029 were observed to have bed rails in use on their beds.

Interview with the Director of Nursing revealed that the home does not have a specific resident assessment for bed rails. Often the Physiotherapist will address this during their assessment of the resident with regards to bed mobility and transfers or nursing will assess and document on the care plan.

Clinical record review did not reveal an assessment of resident #001, #011, #016, #026 and #029 and their use of bed rails. Where bed rails are used, the resident was not assessed in accordance with prevailing practices to minimize risk to the resident. [s. 15. (1) (a)]

2. The licensee has failed to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Resident #001 had bed rails in use on their bed. With minimal pressure the mattress slid laterally on the bed causing a gap between the rails and the mattress thus causing a potential zone of entrapment within zone 3. There were no corner mattress keepers noted on the bed to secure the mattress in place.

Resident #011 was observed to have bed rails in use. One of the bed rails had a potential entrapment risk within zone 1.

The Maintenance Manager and Administrator were shown resident #001 and #011 beds and the potential risks. They confirmed that there were risks of entrapment for residents #001 and #011. [s. 15. (1) (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres.

On April 30, 2015 and on May 7, 2015 it was noted that the mechanism to restrict two windows were loose allowing them to be moved thus allowing the window to open greater than 15 centimetres.

On May 7, 2015 the Maintenance Man and Administrator were shown the two windows and confirmed that the mechanism to restrict the window from opening only 15 cm was loose and that it could be easily moved allowing the window to open greater than 15 centimetres. [s. 16.]

2. On April 29, 2015 it was noted that one window in an identified resident room opened sixty centimetres (cm). The mechanism the home utilized to restrict the window from opening was loose allowing the window to open fully.

On April 29, 2015 the Administrator was shown the window. The Administrator confirmed that the window should not have been able to be opened over 15 cm and that it needed to be fixed immediately. The home's Maintenance Manager was notified by the Administrator who repaired the window to restrict the opening to 15 cm. [s. 16.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

According to the progress notes resident #029 had an area of altered skin integrity.

The home utilizes Pixalere for wound assessments. Review of the Pixalere documentation revealed that there was no assessment of resident #029's area of altered skin integrity. The RPN Wound Care Champion and the Assistant Director of Care confirmed that resident #029 was not assessed using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. Review of resident #030 progress notes indicated that resident #030 had an area of altered skin integrity.
Review of the Pixalere documentation revealed that an assessment of resident #030 areas of altered skin integrity using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment was not done until 18 days after the area of altered skin integrity was noted. This was confirmed by the Director of Care. [s. 50. (2) (b) (i)]

3. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been assessed by a registered dietitian who is a member of the staff of the home, and has had any changes made to the plan of care related to nutrition and hydration implemented.

According to the progress notes resident #029 had an area of altered skin integrity. The Registered Dietitian (RD) had been following the resident for another reason but there was no notation found in the progress notes, assessments, or physician orders for a specific referral to the RD for altered skin integrity.

Interview with a RPN confirmed that an RD referral was not made for resident #029 when they had an area of altered skin integrity [s. 50. (2) (b) (iii)]

4. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #062 was identified as having an area of altered skin integrity. There was an assessment done however the next assessment was not done until twenty days later. The next assessment was done eight days later and then again seventeen days later.

The RPN Wound Care Champion and ADOC confirmed that resident #062 had not had their area of altered skin integrity assessed weekly. [s. 50. (2) (b) (iv)]

5. Review of resident #030 progress notes indicated that resident #030 had altered skin integrity. Review of the Pixalere documentation revealed that assessments of resident #030 altered skin integrity were done on one day and then not again until twenty days later.

The RPN-Wound Care Champion and Director of Care confirmed that weekly skin assessments were not done for resident #030. [s. 50. (2) (b) (iv)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there is a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes.

An anonymous complaint was received by the Ministry of Health and Long Term Care on March 13, 2015 stating that Personal Support Workers do not have enough continence products for all residents and they are not always supplied with the right sizes. The complaint indicated that staff have to go to a nurse in order to get an extra product as they have the keys to the supply room. It can take up to twenty minutes or more for this process.

Interviews with four Personal Support Workers (PSW) revealed that they access continence products for the residents from their care cart. The carts are stocked each day in the late afternoon and most residents' are provided with one change on each shift, although there a few residents in the home that have two. If they need additional product it is their responsibility to find a registered staff who can access the product from a locked supply room. The staff indicated that during a shift its not uncommon to request extra product several times. Delays occur when they cannot locate the registered staff or if the registered staff is busy with treatments and/or medication administration. These delays can be as long as 20 - 25 minutes and have, in some cases, resulted in the resident being incontinent.

Interview with four registered staff revealed that they usually receive between 1-4 requests each shift for extra product. More requests occur on the evening shift versus days. The registered staff indicated that they do their best to get the product as soon as possible but there may be a delay if they are administering medication or resident

treatments. Staff confirmed that when they provide extra product they are expected to document this on the TENA Emergency Sign Out form, however they indicated that often this is missed.

Record review on May 4, 2015 revealed that the last entry on the TENA Emergency Sign Out form was March 15, 2015. The registered staff confirmed that this form does not reflect the actual requests that they have received from the PSW's for extra continence product.

The home has failed to ensure that there is a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes. [s. 51. (2) (f)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements: 10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the dining and snack service includes a review of the meal and snack times by the Residents' Council.

During an interview with the Resident Council representative they could not recall if the dining and snack service included a review of the meal and snack times by the Residents' Council. Interview with the Activity Coordinator who is the liaison for Resident Council confirmed that the home had a Food Committee and felt that the meal and snack times would be reviewed at that meeting.
Review of the Food Committee meetings did not reveal any documentation regarding the review of the meal and snack times.
The Administrator confirmed that the dining and snack service did not include a review of the meal and snack times by the Residents' Council. [s. 73. (1) 2.]

2. On April 30, 2015 resident #061 was heard coughing. When observed the PSW staff was standing giving resident #061 a drink from the snack cart. Resident #061 was not seated properly in their wheelchair. The Director of Care was shown resident #061 and confirmed the resident was not in a safe position. [s. 73. (1) 10.]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 the dining and snack service includes a review of the meal and snack times by the Residents' Council, to be implemented voluntarily.

WN #7: 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).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rights of residents are fully respected and promoted:
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.

An identified resident was not treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity as the identified resident was told to do things for themself. Interviews done with two staff confirmed that the resident could not do these things without the assistance of one staff.

The identified resident was upset when staff told them to do things on their own. [s. 3. (1) 1.]

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 the rights of residents are fully respected and promoted; 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, to be implemented voluntarily.

WN #8: 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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

The home's policy titled Head Injury Routine effective August 2011 and reviewed February 2015 indicates that when a resident sustains any trauma to the head or has an unwitnessed fall, registered staff are to observe, evaluate and carry out examinations to determine changes in resident's status. The procedure indicates that staff are to use the Glasgow Coma Scale as a documentation tool and vital signs, assess the resident for 72 hours with the following frequency:
- Every half hour for the first 2 hours following the injury
- Every hour for the next 4 hours
- Every 4 hours for the next 8 hours
- Every shift for the remainder of the 72 hour monitoring.

Record review revealed that resident #036 had three falls all of which were unwitnessed. Records did not include a completed Glasgow Coma Scale for these three falls.

Interview with the registered staff revealed that a Head Injury Routine is to be completed for all residents that sustain trauma to the head and for those that have unwitnessed falls. The staff member acknowledged that there were no Head Injury Routines completed for resident #36's three identified falls and confirmed that the home's policy titled Head Injury Routine was not complied with. [s. 8. (1) (a),s. 8. (1) (b)]

2. Caressant Care Nursing & Retirement Homes Ltd. policy and procedure titled wound assessment with a review date October 2014 states that all residents with skin and wound issues shall have these appropriately treated and assessed by the registered staff

in conjunction with the Wound Care Champion and managers in the home. Registered staff shall utilize the E-TAR (Electronic Treatment Administration Record) on Point Click Care and the Pixalere wound assessment program to document and assess wound treatments and wound progress.
All residents with skin and wound issues shall have these areas assessed by registered staff every 7 days.

The procedure states:
When a resident presents with a skin or wound issue, registered staff shall assess the area and appropriately document on Pixalere.
Registered staff shall enter the skin/wound treatment on the E-TAR indicating the specific treatment, frequency of dressing application/changes, 3M products to be used etc.
Weekly the registered staff shall re-assess the skin/wound area and document this on Pixalere.

Resident #030 had no skin/wound treatment noted on the E-TAR indicating the specific treatment, frequency of dressing application/changes, 3M products to be used until 18 days after an area of altered skin integrity was noted. On day 18 resident #030 E-TAR orders were initiated to include treatment and dressing changes.
The RPN Wound Care Champion and ADOC confirmed that the home's policy was not complied with. [s. 8. (1) (a),s. 8. (1) (b)]

3. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

Resident #029 was incontinent and used a product to manage this incontinence.

The home's policy titled Bladder and Bowel Management Program, dated June 2010, states to complete the Caressant Care Continence Assessment on all residents who score a two (2) or higher in the continence section of the MDS assessment or at any time upon resident change of status.

It was noted in Point Click Care (PCC) that the last date of a completed continence assessment on resident #029 was in September 2014 even though the two most recent MDS assessments indicated the resident had a score more than two.

Upon interview with the Director of Care it was confirmed that the Caressant Care Continence Assessment should have been completed on resident #029. [s. 8. (1) (b)]

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 plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that in respect of each of the organized programs there is a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

During an interview with the Administrator on May 8, 2015 it was confirmed that there was no written record relating to the annual evaluation of the home's continence program. [s. 30. (1) 4.]

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 in respect of each of the organized programs there is a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented, to be implemented voluntarily.

WN #10: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the infection prevention and control program.

During the initial tour of home for this inspection, the following was noted in a resident living area:
-outside of an identified room there was an isolation cart that had a contact precaution sign laying on top of the cart
-an identified room had a contact precaution sign on the door with no isolation cart outside of the room
-an identified room had an isolation cart outside the room but no signage posted except for two red dots beside residents names.

Observations made seven days later revealed the same.

An interview with staff confirmed that there should be an isolation cart outside the resident's rooms that have contact precaution signage posted.

The explanation from the Director of Care for the inconsistency in signage/carts was that the residents in the identified rooms had been recently discharged. [s. 229. (4)]

2. During this inspection a contact precautions sign was observed posted on the door to resident #012's room. Interviews with two Personal Support Workers revealed that they were not sure why there was a contact precautions sign posted on resident #012's door.

On an identified date the following was observed:
-Three isolation carts were sitting outside of three resident rooms. There was no signage identifying contact precautions.

The RAI Coordinator confirmed that the three residents should of had signage posted on their room doors. The Director of Nursing confirmed that resident #012 should of had an isolation cart outside of their room.

Staff in the home did not participate in the implementation of the infection prevention and control program. [s. 229. (4)]

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 participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

During an initial tour of the home on April 28, 2015 observations revealed the following:

A rusted area near the drain; wall tiles broken and ceiling damage in the shower room. Flooring in front of the fish tank is discoloured and stained white and the lower portion of the wall near the fish tank was damaged.

On April 28, 2015 inspector #155 noted an electric outlet in an identified room that was hanging out of the wall.

On May 7, 2015 the Maintenance Manager acknowledged the areas of disrepair identified above and confirmed that these areas were not maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any.

Resident #017 did not have a care conference of the interdisciplinary team held within six weeks following their admission. This was confirmed by the Director of Care who acknowledged that it is the expectation that a six week care conference is held for all residents. [s. 27. (1) (a)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 124. Every licensee of a long-term care home shall ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time. O. Reg. 79/10, s. 124.

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time.

During the medication room observation done on May 7, 2015 the following was noted:
-21 boxes of Dulcolax suppositories (100 per box)
-11 boxes of Glycerin suppositories (24 per box)
-there was also a white plastic container, the size of a small shoebox filled with Dulcolax suppositories.

During an interview with the RN and RPN it was confirmed that this amount of Dulcolax suppositories and Glycerin suppositories was more than a three month supply for the home. [s. 124.]

Issued on this 24th day of July, 2015

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SHARON PERRY (155), DOROTHY GINTHER (568), REBECCA DEWITTE (521), SHERRI GROULX (519)
Inspection No. / No de l'inspection :	2015_171155_0015
Log No. / Registre no:	L-002224-15
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jul 7, 2015
Licensee / Titulaire de permis :	CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED 264 NORWICH AVENUE, WOODSTOCK, ON, N4S-3V9
LTC Home / Foyer de SLD :	CARESSANT CARE ARTHUR NURSING HOME 215 ELIZA STREET, P.O. BOX 700, ARTHUR, ON, N0G-1A0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	LISA CANADA

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

To CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Order / Ordre :

The licensee shall ensure that there is a written plan of care for that sets out:
(c) clear directions to staff and others who provide direct care for each resident for the following:
-resident #062's plan of care to provide clear direction regarding areas of altered skin integrity
-resident #026 and #016 and any other resident using bed rails that the plan of care to provide clear direction regarding the use of bed rails
-resident #006 plan of care to provide clear direction regarding transferring and toileting.

Grounds / Motifs :

1. LTCHA, 2007, S.O. 2007, s.8, s.6.(1)(c) has been previously issued as a written notification and voluntary plan of correction during inspection 2014_226192_0038 on November 13, 2014; as a written notification during inspection 2014_271532_0020 on June 10, 2014; as a written notification and a voluntary plan of correction during inspections 2012_171155_0011 on October 10, 2012 and 2012_092203_0034 on August 13, 2012.

Review of Pixalere wound documentation for resident #062 indicated that resident #062 had an area of altered skin integrity. Review of the Treatment Administration Record (TAR) which is part of the plan of care for resident #062 indicated that the area of altered skin integrity was in a different location than documented in the Pixalere documentation.

The RPN-Wound Care Champion and the Assistant Director of Care confirmed that resident #062 did not have an area of altered skin integrity in the location as mentioned in the TAR and confirmed that the TAR did not provide clear direction. (155)

2. During stage one of this inspection it was noted that resident #026 had bed rails up on their bed. There was a sign above resident #026's bed that indicated that the resident did not use any bed rails.

Upon interview with the resident it was confirmed that they use bed rails. Interview with the RPN confirmed that the sign above resident # 026's bed did not provide clear direction to staff and others who provide direct care to the resident as it indicated that no bed rails were used and the resident had bed rails in use. The RPN stated that they were in the process of updating signs that did not display current information. (519)

3. The transfer logo above resident #006's bed indicates that the resident needs assistance with transferring.
The care plan for transferring for resident #006 indicates that the goal is to maintain ability to transfer self and the resident needs assistance of one person to transfer.
The care plan for toileting for resident #006 indicates the goal is to maintain ability to toilet self safely and resident requires extensive assistance with one staff member. It also states that most of the time the resident will take self to toilet but when needs assistance will ask.
Resident #006 and two PSWs confirmed in interviews that the resident does not toilet self but requires the assistance of one staff for toileting.
The RPN/RAI Coordinator confirmed that the care plan for resident #006 does not provide clear direction and that resident #006 does require one person assistance for transfers and toileting. (155)

4. During this inspection resident #016 was observed in bed with bed rails in use.

Staff interview revealed that resident #016 uses half bed rails on both sides. When the staff member was asked how they know what bed rails are to used for a resident they indicated that it was posted above the residents bed.
Observation of the posting above resident #016's bed indicates that the resident does use bed rails. Review of the resident's plan of care including the

Physiotherapy Assessment, kardex and care plan did not reveal that the resident used bed rails.

Interview with the RAI Coordinator acknowledged that resident #016 does use bed rails and confirmed that the plan of care does not provide clear direction to the staff and others that provide direct care. (568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 21, 2015

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2014_226192_0038, CO #003;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall ensure that where bed rails are used:
a) the resident is assessed and his or her bed system is evaluated to minimize risk to the resident and
b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Grounds / Motifs :

1. This was previously issued as a compliance order (inspection number 2014_226192_0038, CO #003 issued December 18, 2014 with a compliance date of March 27, 2015).

(155)

2. During this inspection resident #001, #011, #016, #026 and #029 were observed to have bed rails in use on their beds.
(519)

3. Interview with the Director of Nursing revealed that the home does not have a specific resident assessment for bed rails. Often the Physiotherapist will address this during their assessment of the resident with regards to bed mobility and transfers or nursing will assess and document on the care plan. (519)

4. Clinical record review did not reveal an assessment of resident #001, #011, #016, #026 and #029 and their use of bed rails. Where bed rails are used, the resident was not assessed in accordance with prevailing practices to minimize risk to the resident. (568)

5. The licensee has failed to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Resident #001 had bed rails in use on their bed. With minimal pressure the mattress slid laterally on the bed causing a gap between the rails and the mattress thus causing a potential zone of entrapment within zone 3. There were no corner mattress keepers noted on the bed to secure the mattress in place.

Resident #011 was observed to have bed rails in use. One of the bed rails has a potential entrapment risk within zone 1.

The Maintenance Manager and Administrator were shown resident #001 and #011 beds and the potential risks. They confirmed that there were risks of entrapment for residents #001 and #011. (155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 08, 2015

Order # / Ordre no : 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2014_226192_0038, CO #007;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Order / Ordre :

The licensee shall ensure that every window in the home that opens to the outdoors and is accessible to resident has a screen and cannot be opened more than 15 centimetres.

Grounds / Motifs :

1. This was previously issued as a compliance order (inspection number 2014_226192_0038, CO #007 issued December 18, 2014 with a compliance date of January 30, 2015 and during inspection 2012_092203_0034, CO #002 issued September 7, 2012).

On April 29, 2015 it was noted that one window in an identified room opened sixty centimetres. The mechanism the home utilized to restrict the window from opening was loose allowing the window to open fully.

On April 29, 2015 the Administrator was shown that the window. The Administrator confirmed that the window should not have been able to be opened over 15 centimetres and that it needed to be fixed immediately. The home's Maintenance Manager was notified by the Administrator who repaired the window to restrict the opening to 15 centimetres. (519)

2. On April 30, 2015 and on May 7, 2015 it was noted that the mechanism to restrict two windows were loose allowing them to be moved thus allowing the window to open greater than 15 centimetres.

On May 7, 2015 the Maintenance Man and Administrator were shown the two windows and confirmed that the mechanism to restrict the window from opening only 15 centimetres was loose and that it could be easily moved allowing the window to open greater than 15 centimetres.

(155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 27, 2015

Order # / Ordre no : 004

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2014_226192_0038, CO #005;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Grounds / Motifs :

1. This was previously issued as a compliance order (inspection number 2014_226192_0038, CO #005 issued December 18, 2014 with a compliance date of February 27, 2015).

Review of resident #030 progress notes indicated that resident #030 had an area of altered skin integrity.

Review of the Pixalere documentation revealed that an assessment of resident #030 areas of altered skin integrity using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment was not done until 18 days after the area of altered skin integrity was noted. This was confirmed by the Director of Care. (155)

2. According to the progress notes resident # 029 had an area of altered skin integrity.

The home utilizes Pixalere for wound assessments. Review of the Pixalere documentation revealed that there was no assessment of resident #029's area of altered skin integrity. The RPN-Wound Care Champion and the Assistant Director of Care confirmed that resident #029 was not assessed using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment. (519)

3. According to the progress notes resident # 029 had an area of altered skin integrity. The Registered Dietitian (RD) had been following the resident for another reason but there was no notation found in the progress notes, assessments, or physician orders for a specific referral to the RD for altered skin

integrity.

Interview with a RPN confirmed that an RD referral was not made for resident # 029 when they had an area of altered skin integrity. (519)

4. Review of resident #030 progress notes indicated that resident #030 had an area of altered skin integrity. Review of the Pixalere documentation revealed that assessments of resident #030 areas of altered skin integrity were done on one day and then not again until twenty days later.

The RPN-Wound Care Champion and the Director of Care confirmed that weekly skin assessments were not done for resident #030. (155)

5. Resident #062 was identified as having an area of altered skin integrity. There was an assessment done however the next assessment was not done until twenty days later. The next assessment was done eight days later and then again seventeen days later.

The RPN-Wound Care Champion and ADOC confirmed that resident #062 has not had their area of altered skin integrity assessed weekly. (155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 21, 2015

Order # / Ordre no : 005

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2014_226192_0038, CO #006;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 51. (2) Every licensee of a long-term care home shall ensure that,

(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Order / Ordre :

The licensee shall ensure that there is a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes to keep the residents clean, dry and comfortable.

Grounds / Motifs :

1. This was previously issued as a compliance order (inspection number 2014_226192_0038, CO #006 issued December 18, 2014 with a compliance date of February 27, 2015).

An anonymous complaint was received by the Ministry of Health and Long Term Care on March 13, 2015 stating that Personal Support Workers do not have enough continence products for all residents and they are not always supplied with the right sizes. The complaint indicated that staff have to go to a nurse in order to get an extra product as they have the keys to the supply room. It can take up to twenty minutes or more for this process.

Interviews with four Personal Support Workers (PSW) revealed that they access continence products for the residents from their care cart. The carts are stocked each day in the late afternoon and most residents' are provided with one change on each shift, although there a few residents in the home that have two. If they need additional product it is their responsibility to find a registered staff who can access the product from a locked supply room. The staff indicated that during a shift it's not uncommon to request extra product several times. Delays occur when they cannot locate the registered staff or if the registered staff is busy with treatments and/or medication administration. These delays can be as long as 20 - 25 minutes and have, in some cases, resulted in the resident being incontinent.

Interview with four registered staff revealed that they usually receive between 1-4 requests each shift for extra product. More requests occur on the evening shift versus days. The registered staff indicated that they do their best to get the product as soon as possible but there may be a delay if they are administering medication or resident treatments. Staff confirmed that when they provide extra product they are expected to document this on the TENA Emergency Sign Out form, however they indicated that often this is missed.

Record review on May 4, 2015 revealed that the last entry on the TENA Emergency Sign Out form was March 15, 2015. The registered staff confirmed that this form does not reflect the actual requests that they have received from the PSW's for extra continence product.

The home has failed to ensure that there is a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes.

(568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 08, 2015

Order # / Ordre no : 006

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2014_226192_0038, CO #008;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee shall ensure that resident #061 and any other residents needing assistance with eating are positioned safely while receiving assistance.

Grounds / Motifs :

1. This was previously issued as a compliance order (inspection number 2014_226192_0038, CO #008 issued December 18, 2014 with a compliance date of December 31, 2014). During this previous inspection the same resident was observed not to be positioned safely while receiving assistance with eating.

On April 30, 2015 resident #061 was heard coughing. When observed the PSW staff was standing giving resident #061 a drink form the snack cart. Resident #061 was not seated properly in their wheelchair. The Director of Care was shown resident #061 and confirmed the resident was not in a safe position. (155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 27, 2015

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 7th day of July, 2015

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : SHARON PERRY

Service Area Office /
Bureau régional de services : London Service Area Office