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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 15, 2017	2017_448155_0005	004221-17	Resident Quality Inspection

Licensee/Titulaire de permis

CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE WOODSTOCK ON N4S 3V9

Long-Term Care Home/Foyer de soins de longue durée

CARESSANT CARE 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), MARIAN MACDONALD (137), 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): March 20, 21, 22, 23, 24, 28, 29, 30, 31, 2017.

The following intakes were completed within the RQI:
-Log 016033-16/017075-16 - 2748-000017-16 and 2748-000019-16 same critical incident submitted twice related to alleged staff to resident abuse;
-Log 034059-16 - 2748-000025-16 critical incident related to alleged staff to resident abuse;

-Log 028871-16 - 2748-000024-16 critical incident related to a fall resulting in injury/change in condition;
-Log 019218-16 - 2748-000013-16 critical incident related to a fall resulting in injury/change in condition; and
-Log 022675-16 follow up inspection to inspection 2016_325568_0010 compliance order #001 related to plan of care not providing clear directions to staff and others who provide direct care related to toileting, CO#002 related to staffing plan did not provide far a staffing mix that was consistent with residents' assessed care and safety needs; CO#003 related to not having a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for required changes; and CO#004 related to not having planned menu items for all diet textures offered and available at each snack.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Nursing, Assistant Director of Nursing, Registered Practical Nurse/Resident Assessment Instrument (RPN/RAI) Coordinator, Maintenance Worker, Housekeepers, Activity Coordinator, Clerical Assistant, Food and Nutritional Manager, Registered Dietitian, Cook, Physician, Nurse Practitioner, Registered Nurse, Registered Practical Nurse, Personal Support Workers, Resident Council representative, Family Council representative, residents and families.

The inspectors also toured the home, observed meal service, snack service, medication administration, medication storage; reviewed clinical records, policies and procedures, meeting minutes, schedules, posting of required information, employee files, internal investigation notes, education records; observed the provision of resident care, resident-staff interactions, and observed the general maintenance, cleanliness, safety and condition of the home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
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
Reporting and Complaints
Residents' Council
Responsive Behaviours
Skin and Wound Care
Snack Observation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **4 VPC(s)**
- **0 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:

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REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 31. (3)	CO #002	2016_325568_0010	137
O.Reg 79/10 s. 51. (2)	CO #003	2016_325568_0010	137
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #001	2016_325568_0010	155
O.Reg 79/10 s. 71. (4)	CO #004	2016_325568_0010	155

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 were 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.

During this Resident Quality Inspection (RQI), a resident shared that two identified staff had rushed them and subsequently were rough with them during care.

The inspector reported this to the Director of Nursing (DON) and an investigation was started by the DON.

During an interview with one of the identified staff, it was stated that the resident was not cheerful in the mornings when care was provided. When asked by the inspector if they had been rushed and rough with the resident during care they denied this.

During an interview with the other identified staff, it was stated that mornings were not very good for the resident. The identified staff shared that mornings were fast and that the resident was slow when they moved. The staff member denied ever being rough with the resident.

During an interview with the Director of Nursing (DON), it was stated that the identified resident had been interviewed by the DON. During the process of the investigation the resident repeated the allegation to them that the identified staff had been rough during care. The DON stated that upon interview with an identified staff it was stated that the resident could often be cranky and not satisfied with the care they received. The DON interviewed the identified staff, who both denied being rough with the resident during care but did admit that they were often rushed with morning care.

The licensee failed to ensure that the resident was treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity when the identified staff rushed the resident with their morning care. [s. 3. (1) 1.]

2. The licensee failed to ensure that the following rights of residents were 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.

During an inspection on a Critical Incident System (CIS) report, an identified resident

alleged that an identified staff member had emotionally abused them when their call bell was purposely not answered and care was not provided.

During an interview with the identified resident during this inspection, it was stated that on an identified date they had complained about the staff member as they felt bad that their call bell was not being answered on purpose. The resident shared with the inspector that it had improved since they advised the management of the home and there were no longer issues with the care provided by the identified staff.

During an interview with the identified staff member, it was stated that they would enter the resident's room but that their facial expressions were often misperceived as angry looking. The identified staff shared that at times the resident needed more assistance than they could provide so they would go into the room to turn off the call bell, but not always have assistance from other staff to attend to the needs of the resident.

During an interview with the Director of Nursing (DON), they shared that the staff member was informed to seek assistance from registered staff and management when they were not able to provide assistance to a resident. The DON told the identified staff member not to leave a resident's room without an explanation about when they would return. The DON stated that the resident was not treated with respect and dignity when the identified staff went into the resident's room to shut off the call bell and did not explain that they would return with assistance.

During this inspection this non-compliance was found to have a severity level of minimal harm or potential for actual harm (level 2), the scope was pattern (level 2) and there was previous non-compliance issued in a similar area in the last three years (level 3). [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 following rights or residents are fully respected and promoted: that 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 #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 :

1. The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

The Minimum Data Set (MDS) assessment showed that an identified resident was frequently incontinent of bladder and pads or briefs were used.
A continence assessment showed that the resident wore a product on evenings and nights.
A review of the Point of Care (POC) tasks, for a fourteen day period showed that there was documented evidence that the resident was incontinent of urine for 40 incidents and continent for one incident.
An identified Personal Support Worker (PSW) said that the resident was incontinent.
A review of the plan of care for the resident showed the resident was continent of bladder, with interventions as identified in the resident profile tena list.

The Minimum Data Set (MDS) assessment showed that an identified resident was frequently incontinent of bladder and pads or briefs were used.
A continence assessment showed that the resident wore products during days and

evenings.
A review of the Point of Care (POC) tasks, for a fourteen day period showed that there was documented evidence that the resident was incontinent of urine for 25 incidents and continent for 15 incidents.
A Personal Support Worker (PSW) shared that the identified resident was usually continent on days.
A review of the plan of care for this resident showed the resident was occasionally incontinent of bladder, with interventions as identified in the resident profile tena list.

The Minimum Data Set (MDS) assessment showed that another identified resident was frequently incontinent of bladder.
A continence assessment showed that the resident wore a product at times.
A review of the Point of Care (POC) tasks, for a fourteen day period showed that there was documented evidence that the resident was incontinent of urine for 40 incidents and continent for one incident.
A Personal Support Worker (PSW) shared that the resident was incontinent.
A review of the plan of care for the resident showed the resident was continent of bladder unless the resident could not get to a washroom on time, with interventions as identified in the resident profile tena list.

During an interview with the Director of Nursing they shared that the plan of care was not based on the assessments of the residents.

The licensee failed to ensure that the care set out in the plan of care is based on an assessment of the resident.

During this inspection this non-compliance was found to have a severity level of minimum risk (level 1), the scope was widespread (level 3), and there was previous non-compliance issued in a similar area in the last three years (level 3). [s. 6. (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 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, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that the following rules were complied with: 1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be, i. kept closed and locked.

During the initial tour of the Resident Quality Inspection (RQI), it was noted that the door at the end of a hallway, leading to the outside, was unlocked and able to be opened by the inspector.

A Health Care Aide (HCA) was seated by the door working at a laptop station at the time and was asked by the inspector to attempt to open the same door. The HCA was able to open the door without entering the secure code in the mag-lock pin pad beside the door. The HCA immediately notified the maintenance worker who also was able to open the door without entering the secure code in the mag-lock pin pad beside the door.

The inspector asked the HCA to stay by the door and this was reported to the Director of Nursing (DON). The DON assigned a staff member to monitor the door until it could be repaired.

The maintenance worker notified Georgian Bay Fire and Safety who were dispatched at 1145 hours and completed the repair of the mag-lock system for the identified door at 1330 hours.

The licensee failed to ensure that the door, at the end of the hallway on an identified unit leading to the outside, was kept closed and locked when the inspector and two staff members of the home were able to open the door without entering the secure code in the mag-lock pin pad.

During this inspection this non-compliance was found to have a severity level of minimal harm or potential for actual harm (level 2), the scope was isolated (level 1) and there was unrelated non-compliance issued in the last three years (level 2). [s. 9. (1) 1. i.]

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 all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be, kept closed and locked, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff received retraining annually relating to the following:

The Residents' Bill of Rights,
The home's policy to promote zero tolerance of abuse and neglect of residents,
The duty to make mandatory reports under section 24, and
The whistle-blowing protection.

During this Resident Quality Inspection (RQI), a resident shared that two identified staff had rushed them and subsequently were rough with them during care.

Upon review of an identified employee's record it was noted that this staff had received counselling from the home on previous occasions that all had to do with resident care.

Upon review of another identified employee's record it was noted that this staff had received counselling from the home on previous occasions that addressed issues with resident care.

Upon review of the home's staff education records, it was noted that the identified staff had not had their annual mandatory retraining on abuse and neglect in the year 2016 and so far in 2017, which included the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty to make mandatory reports under section 24, and the whistle-blowing protection.

Upon review of the home's policy titled, "Abuse and Neglect - Staff to Resident, Family to Resident, Resident to Resident, Resident and /or Family to Staff", date of revision February 2017, stated under "Ongoing General Prevention Strategies" - annual education/staff development including: staff obligations to prevent and report abuse/neglect, Residents Rights, Cultural religious and ethnic differences and how they can lead to conflicts, Recognizing signs and symptoms of abuse, and Dealing with aggressive reactions.

Upon interview with the Director of Nursing, it was stated that the home had not provided all direct care staff with abuse retraining in the year 2016, but that a plan was in place to ensure it was completed by all staff in 2017. [s. 76. (4)]

2. The licensee failed to ensure that all staff received retraining annually relating to the following:

The Residents' Bill of Rights,
The home's policy to promote zero tolerance of abuse and neglect of residents,
The duty to make mandatory reports under section 24, and
The whistle-blowing protection.

During an inspection of a Critical Incident System (CIS) report, it was noted that an identified resident had alleged that a staff member took too long to answer the call bell, and had been rough with them during care, which resulted in injury.

During a review of the identified employee's file it was noted that the home counselled this staff member previously.

During a review of the home's staff education records it was noted that the identified staff, last had annual retraining in all of the mandatory education in December 2015, but had not received annual retraining in the year 2016 and so far in 2017 on Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents,

the duty to make mandatory report under section 24, and the whistle blowing protection.

The home's policy titled, "Abuse and Neglect - Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff", date of revision February 2017, stated under "Ongoing General Prevention Strategies" - annual education/staff development including: Staff obligations to prevent and report abuse/neglect, Residents rights, Cultural religious and ethnic differences and how they can lead to conflicts, Recognizing signs and symptoms of abuse, and Dealing with aggressive reactions.

Upon interview with the Director of Care (DON), it was stated that the home had not retrained all of the direct care staff on abuse and neglect in the year 2016, but had a plan in place to ensure it would be completed for 2017.

During this inspection this non-compliance was found to have a severity level of minimal harm or potential for actual harm (level 2), the scope was pattern (level 2) and there was unrelated non-compliance issued in the last three years (level 2). [s. 76. (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 receive retraining annually on the Residents' Bill of Rights, the home's policy to promote zero tolerance of abuse and neglect of residents, the duty under section 24 to make mandatory reports, and whistle blowing protection, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that an identified resident received fingernail care, including the cutting of fingernails.

During resident observations, on two identified dates, the left hand of the resident was observed to have long fingernails, with dark debris underneath the nails.

A review of the bathing records, showed resident had a shower on two identified dates and that fingernails were cleaned and trimmed.

On an identified date, Registered Practical Nurse (RPN) observed the long fingernails, with dark debris underneath the nails, and said the resident's nails needed to be cleaned.

The RPN directed a Personal Support Worker (PSW) to clean and trim the resident's nails.

Director of Nursing (DON) was made aware that the identified resident did not receive fingernail care during the scheduled showers and said that the cleaning and trimming of fingernails should have been completed, when the resident received the scheduled showers.

During this inspection this non-compliance was found to have a severity level of minimum risk (level 1), the scope was isolated (level 1), and there was unrelated non-compliance issued in the last three years (level 2). [s. 35. (2)]

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee failed to seek the advice of the Residents' Council and the Family Council in developing and carrying out the satisfaction survey, and in acting on its results.

During an interview with a Resident Council representative they could not recall that they had any input in developing the satisfaction survey.

A review of the Resident Council meeting minutes was done and there was no mention that the licensee sought the advice of the Resident Council in developing and carrying out the satisfaction survey.

During an interview with the Family Council representative they could not recall that they had any input in developing the satisfaction survey.

A review of the Family Council meeting minutes was done and there was no mention that the licensee sought the advice of the Family Council in developing and carrying out the satisfaction survey.

During and interview with the Activity Coordinator, they shared that the home had done a Resident Satisfaction Survey and a Family Satisfaction Survey but did not recall that they sought the advice of the Residents' Council or the Family Council in developing and carrying out the satisfaction survey.

The Administrator shared that in 2016 the home utilized the use of the InterRAI tool for the satisfaction survey. They did not seek the advice of the Residents' Council and the Family Council in developing and carrying out the satisfaction survey as they wanted to get a baseline from the InterRAI tool. In 2017 they plan to discuss the InterRAI tool with the Residents' Council and Family Council to seek their advice in the development and carrying out the satisfaction survey.

During this inspection this non-compliance was found to have a severity level of minimum risk (level 1), the scope was isolated (level 1), and there was unrelated non-compliance issued in the last three years (level 2). [s. 85. (3)]

Issued on this 25th day of May, 2017

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

Original report signed by the inspector.