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 prévue 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

Central West Service Area Office
500 Weber Street North
WATERLOO ON N2L 4E9
Telephone: (888) 432-7901
Facsimile: (519) 885-9454

Bureau régional de services du Centre-Ouest
500 rue Weber Nord
WATERLOO ON N2L 4E9
Téléphone: (888) 432-7901
Télécopieur: (519) 885-9454

Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 29, 2018	2018_750539_0008	007065-17, 024499-17, 024773-17, 027369-17, 000820-18, 002761-18, 008099-18, 014683-18	Critical Incident System

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue WOODSTOCK ON N4S 3V9

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

Caressant Care 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

VALERIE GOLDRUP (539)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): August 20-24, September 5-7, and September 10 and 11, 2018.

The following intakes were completed during this inspection: 007065-17, 024499-17, 024773-17, 000820-18, 002761-18, 008099-18, related to falls, 027369-17 related to falls and responsive behaviours, and 014683-18 related to a fracture.

PLEASE NOTE: A Written Notification and Compliance Order related to O. Reg. 79/10, s. 52 (2), identified in a concurrent inspection 2018_750539_0007, was issued in this report.

During the course of the inspection the inspector toured the home and observed resident care, services and activities. Clinical records and plans of care for identified residents were reviewed. Also, relevant documents were reviewed including but not limited to the home's documentation and procedures as related to the inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, the Nurse Practitioner, the Resident Assessment Instrument (RAI) Coordinator, the Behavioural Supports Ontario (BSO) RPN, the Behavioural Supports Ontario (BSO) PSW, the Clerical Clerk, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers/ Health Care Aides, Ward Clerks, Family Members and Residents.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Pain
Responsive Behaviours

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

4 WN(s)
2 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A Critical Incident System report (CIS) was submitted for a resident for an incident with injury. Afterwards, a progress note stated that the resident was in a lot of pain during care.

A Pain Assessment Rating Tool in Point Click Care called a PAINAD was not completed at the time of the note. A Pain Assessment under the assessment tab in Point Click Care (PCC) was not completed. The resident's pain medication was not adjusted until two days later.The home's policy entitled, "Pain Assessment", reviewed May 2018, stated that all residents with pain would be assessed.

The Assistant Director of Care (ADOC) stated the home's practice was for registered staff to complete a PAINAD under the vital signs tab and complete a Pain Assessment under the assessment tab for a pain scale rating of 4/10 or greater.

A Registered Practical Nurse (RPN) and the ADOC, stated that the pain assessment should have been completed and the physician called immediately to obtain an increase in the resident's pain medication.

2. A CIS was submitted for a resident for an incident with injury. Progress notes stated that the resident verbalized pain.

The resident's pain medication was not provided to the resident. A Registered Nurse

(RN) reviewed the resident's medication record and confirmed that pain medication had not been provided to the resident at the time of expressed pain.

A RN reviewed the resident's electronic record and was unable to locate a PAINAD assessment or a Pain Assessment under the assessment tab in PCC that should have been completed when the resident complained of pain. The RN stated that registered staff do not always complete a PAINAD.

3. A CIS was submitted for a resident for an incident with injury.

An PAINAD assessment was completed and the resident's pain was assessed as 5/10. The resident did not receive pain medication.

A RN confirmed there was no completed Pain Assessment Tool under the assessment tab in PCC during this time and stated that the pain assessment should have been completed.

4. A resident was assessed twice with the PAINAD as having a numerical pain scale of 4/10 and 10/10.

The home's policy entitled, "Pain Assessment", reviewed May, 2018, stated the Caressant Care Pain Assessment Tool in PCC was to be completed if a resident complained of pain at a level of 4 or greater.

No Pain Assessments were completed under the assessment tab in PCC during this time.

A RN stated that a Pain Assessment under the assessment tab should be completed for a resident with severe pain.

The licensee failed to ensure that when the resident's pain was not relieved by initial interventions, each resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose to ensure each resident’s pain was addressed at the time of identified unrelieved pain.

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. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure staff used safe transferring and positioning devices or techniques when assisting residents.

A Critical Incident System report (CIS) was submitted for a resident regarding improper treatment.

The resident was left unattended by the Personal Support Worker (PSW) who was providing the resident specified care. The resident sustained injury with pain.

The plan of care for the resident was not followed. In the CIS report, the home stated that the resident should not have been left unattended.

The DOC stated that it was the expectation of the home that residents were never to be left unattended when the PSW was providing the specified care to a resident.

The licensee failed to ensure that staff used safe positioning techniques when assisting the resident.

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 staff used safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that actions taken to meet the needs of the resident with responsive behaviours include: assessment, reassessments, interventions, and documentation of the resident's responses to the interventions.

A Critical Incident System Report (CIS) was submitted for a resident for an incident. A review of the clinical record documented a number of responsive behaviours leading up to the incident.

The resident had been referred to the Behavioural Supports Ontario program. Staff were to report new or worsening behavioural symptoms so interventions could be put in place.

A letter from the Waterloo Wellington Local Health Integration Network (LHIN), was located in the BSO binder. It stated that the LHIN provided funding for BSO health care personnel to provide supports and services to older adults with complex and responsive behaviours.

The home’s policy, "Resident Behaviour Management", last reviewed July, 2016, stated a responsive behaviour tracking record would be initiated and completed over 72 hours and a responsive behaviour checklist for potential triggers would be completed.

A PSW and a RPN stated there was a referral and assessment process for resident's experiencing behaviours.They were unable to locate any completed documented assessments for the specified time.

The licensee failed to ensure that actions were taken to meet the needs of a resident with responsive behaviours that included: assessment, reassessments, interventions, and documentation of the resident's responses to the interventions.

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, for each resident demonstrating responsive behaviours, actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented, to be implemented voluntarily.

WN #4: 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 the plan, policy, protocol, procedure, strategy or system was complied with.

O. Reg. 79/10 stated that every licensee of a long-term care home shall ensure that the following interdisciplinary program was developed and implemented in the home, specifically, a falls prevention and management program to reduce the incidence of falls and the risk of injury.

A resident sustained an unwitnessed fall.

The home's policy and procedure entitled, "Safety Plan- Resident", reviewed May 2018, stated under Part C- Post Fall Management to initiate a Head Injury Routine. The home used a paper copy of the Glasgow Coma Scale to document the Head Injury Routine.

A RPN said that the Head Injury Routine would be completed as outlined on the bottom of the sheet. The sheet stated to complete the head injury routine every half hour for the first two hours following a head injury, every hour for the next four hours, every four hours for the next eight hours, finally once in eight hours.

The ADOC stated that a Head Injury Routine would be completed for an unwitnessed fall.The Home's Glasgow Coma Scale form used for monitoring a resident as part of the head injury routine could not be located as completed.

The licensee failed to ensure that any falls plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with to monitor a resident for possible head injury after an unwitnessed fall.

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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Issued on this 30th day of November, 2018

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	VALERIE GOLDRUP (539)
Inspection No. / No de l'inspection :	2018_750539_0008
Log No. / No de registre :	007065-17, 024499-17, 024773-17, 027369-17, 000820-18, 002761-18, 008099-18, 014683-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 29, 2018
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 :	Lindsay Ross

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:

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

Ministère 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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 52(2). The licensee shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Specifically the licensee shall ensure that::
Resident's #001, #002, #003, #004 and any other resident experiencing pain is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A Critical Incident System report (CIS) was submitted for a resident for an incident with injury. Afterwards, a progress note stated that the resident was in a lot of pain during care.

A Pain Assessment Rating Tool in Point Click Care called a PAINAD was not completed at the time of the note. A Pain Assessment under the assessment tab in Point Click Care (PCC) was not completed. The resident's pain medication was not adjusted until two days later.The home's policy entitled, "Pain Assessment", reviewed May 2018, stated that all residents with pain would be assessed.

2. A CIS was submitted for a resident for an incident with injury. Progress notes stated that the resident verbalized pain.

The resident's pain medication was not provided to the resident.

The resident's electronic record did not have a PAINAD assessment or a Pain Assessment under the assessment tab in PCC.

3. A CIS was submitted for a resident for an incident with injury.

An PAINAD assessment was completed and the resident's pain was assessed as 5/10. The resident did not receive pain medication.

The home's policy entitled, "Pain Assessment", reviewed May, 2018, stated the Caressant Care Pain Assessment Tool in PCC was to be completed if a resident complained of pain of 4 at a level four or greater.

There was no completed Pain Assessments under the assessment tab in PCC during this time.

4. A resident was assessed twice with the PAINAD as having a numerical pain scale of 4/10 and 10/10.

No Pain Assessments were completed under the assessment tab in PCC during this time.

A RN stated that a Pain Assessment under the assessment tab should be completed for a resident with severe pain.

The licensee failed to ensure that when the resident's pain was not relieved by initial interventions, each resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose to ensure each resident's pain was addressed at the time of identified unrelieved pain.

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm to the residents. The scope of the issue was a level 3 as it related to four out of five residents. The home had a level 2

compliance history as they had non-compliance within a related section of the Act.

(539)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 29, 2019

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 29th day of November, 2018

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Valerie Goldrup

Service Area Office /
Bureau régional de services : Central West Service Area Office