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

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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_0007	024814-17, 021317-18	Complaint

Licensee/Titulaire de permis

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

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

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 Complaint inspection.

This inspection was conducted on the following date(s): August 20, 21, 22, 23, 24, and September 5 ,6, 7, 10, 11, 2018.

The following intakes were completed during this inspection: Log #024814-17 (IL-53754-LO) and Log #021317-18 (IL-59025-CW), relating to two complaints from a family member regarding care.

PLEASE NOTE: A Written Notification and Compliance Order related to O. Reg. 79/10, s. 52 (2) was identified in this inspection and has been issued in Inspection Report 2018_750539_0008, which was conducted concurrently with this inspection.

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:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Personal Support Services
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

- **3 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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 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).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident was treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity.

A) On a specified date, a complainant placed a call to the Ministry of Health and Long Term Care (MOHLTC) INFOline stating that staff would enter residents' rooms, turn off the call bell and not return for an extended period of time.

B) During the inspection a resident stated that the Personal Support Workers (PSWs) often came to their room, turned off the call bell and stated they would be back and then had to wait extended periods of time.

C) A resident who was a high risk for falls, was observed by the inspector left on the toilet unattended. This was brought to the attention of registered staff to assist the resident as the PSWs were not available to attend.

D) The inspector observed a resident wait forty minutes and receive care after the call bell had been reactivated.

A PSW, when asked about the delay in care, stated that they and another PSW were

providing care to another resident which took greater than twenty minutes. This was the reason the resident was unattended on the toilet, the call bell had been turned off and the other resident had to wait.

E) Another resident stated that some PSWs came to the room, turned off the call bell and stated they would be back, but would frequently forget to come back.

The Assistant Director of Care (ADOC) stated that call bells were not to be turned off without addressing the resident's needs.

The licensee failed to ensure that the residents were treated with courtesy and respect and in a way that fully recognized the resident's individuality and respected the resident's dignity by receiving care when the PSW was called by the resident to assist them.

2. The licensee failed to ensure that every resident was afforded privacy in treatment and caring for his or her personal needs.

The inspector observed two PSWs provide personal care to a resident without asking the family member or the inspector to leave the room or using the privacy curtain so that the resident had privacy while provided assistance.

The ADOC #107 stated that it was the expectation of the home to provide privacy to the resident when providing assistance with personal care.

The licensee failed to ensure that a resident was afforded privacy in caring for their personal needs.

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 the 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 and 8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs, 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

A resident's care plan stated that after dinner the resident was not to be left alone while seated in their wheelchair.

During a specified month, the resident had two falls when left alone.

The ADOC stated that the resident should not have been left alone and the PSWs had not followed the care plan.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan to keep the resident safe.

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 provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) 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. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs.

A) Three complaints indicated call bells went unanswered, residents had to wait extended periods for assistance and some staff had to work double shifts due to staff shortages.

B) Two HCAs stated that there was a shortage of PSWs and that not all baths were getting done or that staff would provide a bed bath in place of a shower or tub bath.

C) A Thirty day look back report for baths for a resident stated that the resident had not received a shower, rather a bed bath, on three occasions.The PSW weekly roster for those dates documented that they were short staffed one PSW.

D) On a specified date, a resident sustained an unwitnessed fall in their room.

A PSW stated that on the date of the fall they were working short of staff in that home area with only two of the scheduled three PSWs. They stated they had been very busy with call bells going off continuously needing to be answered.

E) A resident stated that they have had to wait up to two hours to receive care and that there were times when they had gone up to two weeks without a bath. They stated they did not receive a bath if the home was short staff.

F) The inspector observed a resident angry with a PSW. They asked the PSW when they would receive assistance with care. When asked, the resident stated they had to wait longer when the home was short staffed. The PSW weekly roster documented on that date that they were short two PSWs.

G) Registered Staff stated that PSW staffing was a problem and staff were not wanting to pick up extra shifts in the summer. A Ward Clerk stated that the staffing had become worse recently after nursing students returned to school, as they had been working as PSWs during the summer months. A PSW stated there was a shortage of staff almost every day especially on evenings, nights and weekends.

H) A record review of the PSW weekly rosters from July 2018, to September 2018, documented the home was short of PSWs and unable to fill all positions on 83 of 231 shifts or 36 per cent of the shifts.

I) The Administrator stated that with the last review of the PSW lines completed a month prior they were short seven part-time lines. Each line was five to seven shifts in total in a two week period. They stated that it was difficult to fill all lines given that the home was located in a rural area.

The licensee failed to ensure that the staffing plan provided for a staffing mix that was

consistent with residents' assessed care and safety needs.

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 with having a staffing plan that provides for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation, to be implemented voluntarily.

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.