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

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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
Dec 22, 2014	2014_200148_0044	O-001281-14	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 BOURGET
2279 Laval Street P.O. Box 99 Bourget ON K0A 1E0

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

AMANDA NIXON (148), ANANDRAJ NATARAJAN (573), KATHLEEN SMID (161), MELANIE SARRAZIN (592)

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): December 8-12 and December 15-17, 2014.

The following critical incident and complaint inspections were completed during this Resident Quality Inspection: Log #O-000354-14,#O-000445-14, #O-000514-14, #O-000819-14 and #O-000958-14.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator, Environmental Manager, Nutritional Manager (NM), Nursing Staff Coordinator, Registered Practical Nurses (RPN), Registered Nurses (RN), Personal Support Workers (PSW), Housekeeping staff, Food Service Workers, Physiotherapist, family members and residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

15 WN(s)
3 VPC(s)
2 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	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 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 :

The licensee failed to ensure that where the Act or 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 requires to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with.

In accordance with the LTCHA 2007, s.29 and O.Reg 79/10, s.109 the licensee shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations. Further to this section 109 of the Regulations describes the content, at minimum, to be included within the policy to minimize restraints.

In accordance with LTCHA 2007, s.30 and s.31, a resident is restrained by a physical device when the resident is not able to physically or cognitively remove the device, the device has been included in the plan of care which includes, but is not limited to, the significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.

Upon request for the licensee's policy to minimize restraints, the home's Administrator identified the Safety Plan –Resident, policy effective September 2013.

The policy describes the following:
-Alternative approaches to the use of restraints, the use of Appendix A (Safety Plan Interventions) to ensure alternatives have been explored

- Consent to be obtained from resident or resident substitute decision maker if the resident is not capable to make a decision related to the restraint. The Resident Safety Plan is to be discussed, if discussed over the phone, a copy of the Resident Safety Plan must be mailed to them. Record of consent discussion will be recorded on Appendix B (Consent to Use of Restraint).
- Obtain an order from a physician or registered nurse in the extended class. The order must include the type of restraint, reason for restraint and duration of application. Restraints must be applied in accordance with instructions specified in the order.
- Physical restraints include, front closing lap belts, 10 lb closure clasps (seatbelts), rear closing lap belts, table trays used for other than eating or activation, geri-chairs and tilt chairs.
- Registered nursing staff must reassess the resident's condition and evaluate effectiveness at least every 8 hours. A task will be added to the electronic medication administration record, whereby registered staff are to sign off at the start of shift, indicating the restraint has been assessed and whether the restraint is to be continued.
- Registered nursing staff much ensure that every use of a physical device to restrain a resident is fully documented in the resident's progress notes, including but not limited to, circumstances precipitating the application of the restraint, alternative considered and why the alternative were inappropriate, person who applied the device and the time of application, all assessments, reassessments, monitoring, release and repositioning , removal or discontinuance of the restraint.
- Each month the DON will host a multidisciplinary meeting on each resident with a physical restraining device, using Part A of this policy to review the Resident Safety Plan. This meeting is to be documented in the progress notes.

Resident #9 was observed between December 8-11, 2014 to be seated in a geri-chair with table top applied. At times the table top was applied at meals, released when the meal service was complete. At other times the resident was observed to be seated with a table top applied outside of meal service. Inspector #148 confirmed that the resident is unable to release the table top from the geri-chair.

Inspector #148 spoke with RN #S102 regarding the purpose of the table top. RN #S102 indicated that the table top is used at meals as the resident is known to wander and he will not always stay at the meals to complete his/her meal. On the following day, the Inspector spoke with RPN #S103, who confirmed the use of the geri-chair and table top as a personal assistive service device at meals. RPN #103 also reported that the resident will wander about the hallways and enter resident rooms, the resident will disturb other residents and some incidents have led to physical altercations. The resident will be

placed in a chair with table top to inhibit the resident from wandering into resident rooms to rummage and hoard. RPN #103 also indicated that the resident may be placed in the chair with table top if he/she has been wandering for too long and appears tired. The chair and table top will be applied so that the resident will have rest periods to prevent falls. At the point in time the geri-chair and table top are used to limit/inhibit the residents movement for the purposes of safety, the table top is considered a restraint under section 31 of the Act.

The most recent Minimum Data Set assessment was reviewed. Although coding of the MDS assessment indicates that no physical devices or restraints are used, the Resident Assessment Protocols confirm that the resident is placed in the geri-chair for short periods due to excessive wandering and high risk for falls. In addition, the geri-chair is used when the resident is wandering in and out of resident rooms rummaging and hoarding items.

The plan of care for Resident #9 indicates the use of the geri-chair under items of aggression and wandering. The use of the geri-chair with table top is further noted as an intervention under the item of rummaging and hoarding; "use geri chair with table top PRN for agitation/aggressive wandering behaviours".

The physician orders, for Resident #9, indicates on specified date; "Put resident in a jerry chair with table top as necessary for wandering and reassess after an hour". A physician order approximately 1 month later; "Geri chair QID for a maximum of 1 HR Also geri chair QID PRN x 1 hour". The current 3 month Medication Review, which discontinues all previous orders, indicates "Geri chair - use QID for maximum of 1 hour, Also QID PRN". As of December 10, 2014 no order from a physician or registered nurse in the extended class was in existence for the use of a geri-chair and table top for the purpose of restraining the resident related to significant risk to the resident or others.

A review of the health care record demonstrated the Safety Plan Interventions (Appendix A, as per the policy) to explore alternatives to restraining, was not completed at any time for Resident #9.

A review of the health care record demonstrates that the Consent Form (Appendix B, as per the policy), was initiated on a specified date and a verbal consent was received from the substitute decision maker (SDM) for Resident #9 for the use of a geri-chair PRN with tabletop and to assess after one hour for wandering to another resident's room. The Consent Form is incomplete and the progress note of the same date, does not support

that a discussion of all aspects covered by the Consent Form were discussed, as per the home's policy.

A review of documentation maintained by staff, including Point of Care, indicated that there is no current task assigned to ensure that who has applied the device and the time of application, all assessments, reassessments, monitoring, release and repositioning and removal of the device are documented. The task, "Safety Intervention (seatbelt /table top) in place and in working order daily. HCA Every shift", has been added and is completed by PSW staff members. A task has not been added to the electronic medication administration record, whereby registered staff are to sign off at the start of shift, indicating the restraint has been assessed and whether the restraint is to be continued. Progress notes by registered staff do not indicate all instances of application of the device or all required information, as per the home's policy.

Resident #15 was observed between December 8-11, 2014 to be seated in a wheelchair. At no time during the observations was the resident observed with a seat belt.

Upon review of the resident health care record during the Stage 1 process of the Resident Quality Inspection, the following physician order was in place "wheelchair with seatbelt". The current 3 month Medication Review, indicates "wheelchair with seatbelt for safety".

The plan of care for Resident #15 related to high risk for falls indicates the use of a seatbelt for fall prevention when in wheelchair.

On December 11, 2014, the Inspector spoke with PSW #S107, who is a regular staff member familiar with the care of Resident #15. Staff #S107, when asked about the use of a seatbelt, indicated that the resident does not use a seat belt but rather has a chair alarm. On the same date, the Inspector spoke with RN #S106, who when asked indicated that the resident uses a seat belt when in his/her wheelchair. When informed that the resident was not wearing a seatbelt and had not been seen with a seat belt over the last 3 days, he proceeded to examine the wheelchair. Upon examination it was confirmd that the wheelchair did not have a seat belt for use. The RN proceeded to confirm the physician order and inform the Physiotherapist and DOC of the lack of seat belt. On the afternoon of December 11, 2014, RN had indicated that he had reassessed the resident's need and determined that a seat belt was required due to the resident's lack of strength, inability to weight bear and lack of ability to reposition self. The resident

is known to lean forward at times and may fall out of the wheelchair and injury self.

During the observation period of December 8-11, 2014 the Inspector did not observe the restraint to be applied as per the physician order.

A review of the health care record demonstrated the Safety Plan Interventions (Appendix A, as per the policy) to explore alternatives to restraining, was not completed at any time for Resident #15.

A review of the health care record demonstrates that two Consent Forms (Appendix B, as per the policy), were initiated. The forms are incomplete, do not indicate a documented consent was obtained and do not include a date in which the forms were initiated. Two other Consent Forms noted from years past, both relate to the use of a lap belt for an interim period of time.

A review of documentation maintained by staff, including Point of Care, indicated that there is no current task assigned, to ensure that who has applied the device and the time of application, all assessments, reassessments, monitoring, release and repositioning and removal of the device are documented. A task has been added to the electronic medication administration record, whereby registered staff are to sign off at the start of shift, indicating the restraint has been assessed and whether the restraint is to be continued. The December 2014 medication administration record indicates that from December 1-10, 2014, registered staff have signed off that the restraint has been assessed at 0800, 1200 and 1700. This is contrary to observations made by the inspector from December 8-11, 2014, that the resident is not wearing a seat belt.

Resident #19 was observed from December 8-11, 2014 to be seated in a tilt wheelchair with lap belt applied. Inspector #148 confirmed the resident was not able to release the lap belt. At no time during the observations was the resident observed with a table top.

Staff #S105 indicated that Resident #19 is always wearing the lap belt when seated in the wheelchair. When asked by the Inspector, Staff #S105 indicated that the resident also has a table top in his room, but that this is rarely used. Staff #S105 reported that the table top is used for activities primarily.

The current physician order for Resident #19, includes "seatbelt and table top with tilt wheelchair for safety/prevent falls". A review of the December 2014 medication administration record indicates "seat belt or table top while in wheelchair (tilt) to prevent

falls, table top/seatbelt restraint if needed for residents' safety, to prevent fall if applied reassess hourly."

The plan of care for Resident #19 was reviewed and indicates the use of a seat belt and/or table top restraint for prevention of falls and safety and uses seatbelt/lap table for fall prevention when in wheelchair. The plan of care further describes that the resident is provided a chemical restraint.

Inspector spoke with the RAI Coordinator, who assists to maintain the plans of care, she reported that the resident was to have both the seat belt and table top in place.

A review of the health care record demonstrated the Safety Plan Interventions (Appendix A, as per the policy) to explore alternatives to restraining, was not completed at any time for Resident #19.

During the observation period of December 8-11, 2014, the Inspector did not observe the restraint to be applied as per the physician order.

The plan of care for Resident #19 indicates the use of chemical restraint, which is contrary to the home's policy. The policy indicates that the licensee does not condone the use of chemical restrains other than in emergent situations when immediate action is necessary to prevent serious bodily harm. To note, the Inspector reviewed the medication administrator record for Resident #19 and it does not appear that chemical restraining is used for this resident.

A review of the health care record demonstrates that two Consent Forms (Appendix B, as per the policy), were initiated over 1 year ago related to physical restraints. The forms indicate the use of a seatbelt or table top restraint if needed/required for behaviours/agitation to prevent falls/safety. The consents obtained are not accurate to the current physician order or current use of the physical devices.

A review of documentation maintained by staff, including Point of Care, indicated a current task is assigned to the Kardex, there is no task assigned, to ensure that who has applied the device and the time of application, all assessments, reassessments, monitoring, release and repositioning and removal of the device are documented. A task has been added to the electronic medication administration record, whereby registered staff are to sign off every hour, indicating that the restraints (including seatbelt or table top or bed rails) has been assessed and whether the restraint is to be continued.

The documentation is unspecific to which physical restraint is applied at what hour of the day.

The home is not following the policy titled Safety Plan – Residents, which was identified as the home's policy to minimize restraints. As demonstrated by the findings above, physical restraining has been included in the resident plan of care without assessment of alternatives to physical restraining, residents have not been provided physical devices for restraining as indicated by plan of care and/or physician order, the plan of care and/or physician orders have not provided clear direction to staff in the application of the physical restraints, consents have not been obtained using the process outlined by Appendix A of the policy and/or do not provide accurate information as to the use of the physical device. In addition, procedures to ensure required documentation is completed by respective staff members, is not put in place as per the home's policy. In addition, on December 11, 2014, the Inspector spoke with the DOC related to the policy requirement of monthly meetings to discuss physical restraining devices. The DOC, indicated that monthly multidisciplinary meetings have not been held for each resident with a physical device, including Resident #9, #15 or #19.

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. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

The licensee failed to ensure that lingering offensive odours are addressed in resident home areas on the 1st floor, including common areas, hallways and residents shared bathrooms, despite routine cleaning.

The licensee has a history of non-compliance related to lingering offensive odors. Most recently, a Voluntary Plan of Corrective Action (VPC) was issued on November 26, 2014 as a result of inspection #2014_198117_0023. Prior to this, there has been non-compliance issued to the home on the following dates: February 26, 2013 a Voluntary Plan of Correction was issued as a result of inspection # 2013_193150_0002 and on August 28th, 2012 a Voluntary Plan of Correction as a result of inspection # 2012_054133_0035.

Throughout the course of this inspection, lingering offensive odors were noted by Inspectors #161, #148, #573 and #592 pervasively in resident home areas on 1st Floor including hallways, lounge areas and Resident shared bathrooms.

On December 8 and 10, 2014, Inspector #573 noted strong offensive urine odour particularly in three identified residents shared bathrooms. It was also observed by the Inspector that the identified bathroom floor tiles were stained with dried urine spots around the toilet.

On December 12, 2014, at 13:34 hours Inspector #573 observed strong offensive urine odour in and identified resident shared bathroom.

On December 16, 2014, Inspector #573 spoke with housekeeping Staff #S121 who stated that he is aware of the lingering offensive odors in three identified shared resident bathroom. Staff #S121 informed Inspector that the housekeeping staff are assigned to clean those residents shared bathrooms more than once in a day and yet despite routine cleaning they remain odorous. Housekeeping Staff #S121 indicated that they use neutral disinfectant cleaning agent (R2A) which they use on other resident bathrooms and air fresheners on fabric (Fresh Face) to control the odour. Staff #S121 further stated that they do not have any specific products and other interventions in place to manage the incidents of lingering offensive odours in those identified shared bathrooms.

On December 16, 2014, at 15:08 hours, during a walk-about of the home with the Environmental Manager (EM), it was reported that a lingering offensive odor was present on the 1st floor hallway near two resident bedrooms. The EM agreed with the Inspector regarding the strong urine odour in one identified resident bathroom and stated that the resident bathroom requires a good cleaning.

The EM stated that for resident bathrooms, in two of the identified rooms, the strong urine odour is coming from underneath the toilet bowl gasket and floor tile. The EM

stated to the Inspector that a work order is placed to change the toilet bowl gasket and caulking around the toilet sink for both two identified bathrooms. The EM further stated that the home does not have any products other than disinfectant cleaning agents for managing incidents of lingering offensive odours in the home.

The EM informed the Inspector that the home manages odour control in the home by using disinfectant cleaning agents, air fresheners and by changing the toilet gaskets.

On December 12, 2014, Inspector #573 reviewed the home policy and procedure regarding odour control, while the odour control policy and procedure indicates how to control odour in the home, the home failed to address and manage incidents of lingering offensive odours, as identified in the resident home areas on the 1st Floor including hallways and residents shared bathrooms in identified rooms, during the course of this inspection.

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 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 :

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

The following observations were made by Inspector #573, throughout the course of the inspection, specifically on the 1st floor:

The varnish on the wooden hand rails on both sides of the hallway on the 1st floor, from resident room #1 to room #13 is worn off exposing the grain of wood and is chipped along the edges of the hand rails.

The wall between the resident t.v. room on the first floor and the door to 2nd floor stairs had horizontal scuff marks approximately ten inches from the bottom of the wall, running across the wall for a six foot section.

There were also horizontal scratches on the metal part of the door in the resident t.v. room.

In an identified resident bedroom – on the inner side of the bathroom door about twenty inches high, there are horizontal scratches from one end of the door to the other. There were also scratches down to the metal part on the bottom foot of the inner side of both the bathroom doors.

In an identified resident bedroom – resident Bi-Fold closet door was broken on the left side exposing approximately a 20 inch gap in the closet door.

In an identified resident bedroom – related to home furnishing, observed a storage chest with peeled wooded laminate exposing the metal part on the left side of the chest for about 18 inches. In the bathroom, on both the corners of the bathroom wall, it was observed that the vinyl baseboard was peeling away from the base of the wall, approximately 3 inches.

In an identified resident bedroom – the base board metal heater was broken on the left side exposing the heating coil, approximately 14 inches.

In an identified resident bedroom - there were horizontal scratches down on the metal part on the bottom foot of the inner side of bathroom door. Inside the bathroom there were scratches in the drywall by the grab bar and there is an open area, approximately 5 inch, between the wall and the flooring tiles exposing the subfloor. The wall behind the toilet sink was exposing the gyp rock underneath, approximately 4 inches.

In an identified resident bedroom - there were no doors for the either resident closets,

exposing resident's personal belongings inside the closet.

In an identified resident bedroom – the bathroom door in the shared resident room does not have any door handle from inside to close or open the bathroom door.

In an identified resident bedroom - the wooden door frame to the resident's bathroom was heavily scarred at the corners of the door. There were horizontal scratches down to the metal part on the bottom of the inner side of the bathroom door.

In an identified resident bedroom – in this shared resident room, there are 4 windows that were not able to open and one window had a broken handle crank mechanism.

On December 12, 2014 during an interview, the Environmental Manager and the Administrator both indicated that they were aware of some of the issues identified by Inspector #573. Furthermore, the Administrator stated that they have a work order placed to repair some of the above identified issues related to home maintenance.

The licensee has failed to ensure that the home, furnishings, and equipment are kept clean and sanitary.

On December 8, 2014, while in an identified resident bedroom, Inspector #573 observed a resident's leather chair armrest and cushion to be stained and unclean with a dried white splattered cream like substance all over the chair.

On December 9, 2014, Inspector #573 observed and identified resident's wheelchair wheels and frame to be unclean, specifically the wheelchair had dried food debris on the lower metal frame and wheels. It was also observed that an identified resident's wheelchair seat belt and cushion were heavily stained and soiled with dirt and debris resembling dried food.

On December 12, 2014, during an interview with PSW #S110, it was indicated to Inspector #573 that it is the responsibility of the PSWs on nights to clean resident wheelchairs and further stated that it is expected that PSWs spot clean wheelchairs as required.

On December 12, 2014, Inspector #573 spoke with RPN #S103 who stated that every resident wheelchair is cleaned on a weekly basis by the night PSWs and also indicated that resident wheelchairs are to be cleaned by the PSWs whenever they are observed to

be unclean or dirty. Inspector #573 observed the two identified wheelchairs and one resident leather chair in the presence of the RPN #S103 who agreed that the resident wheelchairs and leather chair were unclean and further indicated that they should be kept clean.

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 home, furnishings and equipment is maintained in a safe condition and in a good state of repair and to ensure that the wheelchairs of resident #2 and #46 are kept clean as required, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

The licensee failed to ensure that the nutrition care and hydration program includes a weight monitoring system to measure and record with respect to each resident, a weight on admission and monthly thereafter and a body mass index and height upon admission and annually thereafter.

As described by the home's DOC and nursing staff the home documents all heights and weights in the electronic health care record (Point Click Care) under the weight and vitals tab. The current month weights may be found in the tub room on hard copy, which are later transcribed into the electronic record by the end of the month and the hard copy discarded.

Upon review of 15 residents randomly selected as part of the Resident Quality Inspection, Stage 1 process, it was determined that all 15 residents did not have a recorded annual height in the health care record. Twelve of the 15 residents had only the admission height on record.

Upon review of 40 residents selected as part of the Resident Quality Inspection, 14 residents residing on the first floor were identified to have one or more monthly weights missing. Resident #30 and #39 were missing 4 monthly weights in the last 6 months, the health care records were reviewed and staff were interviewed; no reason for the missing weights could be identified.

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 with respect to each resident a body weight is measured and recorded monthly and that a height is measured and recorded annually, to be implemented voluntarily.

WN #5: 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. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

Findings/Faits saillants :

The licensee has failed to ensure that at least once in every calendar year, a survey is taken of the residents and their families to measures their satisfaction with the home and the care, services, programs and goods provided at the home.

On December 15th, 2014, the Residents' Council Minutes for March 29th, 2014 up to October 31st, 2014 were revised by inspector #592. No minutes were found indicating that a satisfaction survey was discussed at the council meetings.

During an interview with the Administrator on December 15th 2014, (acting assistant of the Residents' Council) he indicated to Inspector #592 that upon verification with the home's licensee, they were unable to demonstrated that a satisfaction survey was completed for the year of 2013 and 2014 for this home. The Administrator indicated that the home is working on it right now, and the goal is to have the satisfaction survey to be distributed as soon as possible to residents and families.

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 a satisfaction survey is taken at least once a year of residents and their families, in accordance with section 85 (1),(2),(3) and (4) of the Act, to be implemented voluntarily.

WN #6: 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).

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 :

The licensee failed 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.

The plan of care for Resident #22 indicates the resident has a risk for falls related to decreased balance. The resident will ambulate in the home independently and transfer self in and out of bed.

The plan of care related to falls indicates that the resident is to be provided with a fall mat. On December 16, 2014, Inspector#148 observed the resident resting in bed, the resident did not have a fall mat in place at bedside. The Inspector notes that at no time during observations for this resident has a fall mat been observed while resident is in bed.

The Inspector spoke with PSW #S115 who is familiar with the resident, who reported that no fall mat is used for Resident #22. The home's RAI Coordinator, who is primarily responsible for the plan of care, indicated that the resident was thought to be having frequent unwitnessed falls and the fall mat was initiated to prevent any injury from falls from bed. The home has since concluded that the resident is not falling but rather placing him/herself on the floor. For this reason the fall mat is not required as part of the planned care for the resident's fall risk. Therefore, the plan of care related to the use of a fall mat for fall risk, is not based on needs of this resident.

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

Resident #9 was identified to have weight loss and inadequate intake.

The plan of care for Resident #9, indicates that the resident is to be offered second helpings at meals and snacks throughout the day. On December 10, 2014, Inspector #148 observed Resident #9 at the lunch meal service. The resident was observed to be fed the puree meal by a staff member, both soup and entrée were consumed by the resident. While consuming the entrée the Dietary Aid #S105, packed up all food items into the available cambro cart and proceeded to take the food down to the main floor. When Resident #9 was finished the entrée, staff did not offer a second helping nor was there food available on the floor to provide for this second helping.

The care set out in the plan of care related to offering of second helpings was not provided to Resident #9.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 12. Furnishings

Specifically failed to comply with the following:

s. 12. (2)The licensee shall ensure that,
(a) resident beds have a firm, comfortable mattress that is at least 10.16 centimetres thick unless contraindicated as set out in the resident's plan of care; O. Reg. 79/10, s. 12 (2).
(b) resident beds are capable of being elevated at the head and have a headboard and a footboard; O. Reg. 79/10, s. 12 (2).
(c) roll-away beds, day beds, double deck beds, or cots are not used as sleeping accommodation for a resident, except in an emergency; O. Reg. 79/10, s. 12 (2).
(d) a bedside table is provided for every resident; O. Reg. 79/10, s. 12 (2).
(e) a comfortable easy chair is provided for every resident in the resident's bedroom, or that a resident who wishes to provide their own comfortable easy chair is accommodated in doing so; and O. Reg. 79/10, s. 12 (2).
(f) a clothes closet is provided for every resident in the resident's bedroom. O. Reg. 79/10, s. 12 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a comfortable easy chair is provided for every resident in the resident's bedroom.

Throughout this inspection it was observed by Inspector #161 that there was not a comfortable easy chair in resident bedrooms #3, #4, #8, #10, #11 and #201. December 16, 2014 discussion held with the home's Administrator who indicated that these resident bedrooms should have a comfortable easy chair and that he would rectify this issue. [s. 12. (2) (e)]

WN #8: 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 is assessed and his/her bed system is evaluated in accordance with evidence-based practices to minimize risk to the resident.

On December 8, 2014, Inspector #148 observed the bed system for Resident #19. On visual assessment there appeared to be a gap that existed between the foot board and end of mattress. Resident #19 was observed during the inspection, in bed using both full bed rails in the up position. On December 15, 2014, Inspector #148 and the Environmental Manager observed the bed system. The Manager measured the gap to be 5 inches, 6 inches with compression of the mattress. The Manager immediately identified that the mattress was too small for the bed frame and that a mattress was likely available on site for replacement. The Manager is new to the home and indicates that recently he was provided training on bed system assessment, but to date no bed assessments have been done.

Inspector #148 spoke with the home's Administrator who indicated that during his time at the home bed assessments have not been completed to his knowledge. He indicated that it is the home's priority to complete bed system assessments for all bed systems by the end of the year.

As of December 15, 2015, the home could not demonstrate that bed assessments, including the bed system used for Resident #19, have been completed.

On December 17, 2014 the Environmental Manager confirmed with the Inspector that the mattress for the bed in room #208 had been change and a bed assessment completed for this bed system. [s. 15. (1) (a)]

WN #9: 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 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 cm.

Inspector #573 confirmed that windows in resident bedrooms #3, #5, #9, #10, #11, #12, #13 and in bedrooms #201, #203 and #205 to have an opening more than 30cm. In addition, the Inspector observed windows in two of the dining areas to open more than 30cm.

On December 10, 2014, Inspector #573 spoke to the Environmental Manager and the Administrator to confirm the openings of the windows identified above. The Administrator indicated to Inspector #573, that the home was aware of the requirements of section 16 of the Regulation and further stated that steps would be taken immediately to make the necessary modifications to the windows, so that the windows cannot open more than 15cm.

On December 12, 2014 the Environmental Manager notified Inspector #573 that all windows on the 1st and 2nd floor, as identified by the Inspector #573, were modified to ensure that no window opened more than 15cm. [s. 16.]

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
19. Safety risks. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

The Licensee failed to ensure that the plan of care is based on interdisciplinary assessment with respect to safety risk regarding Resident #2's wheel chair in disrepair.

On December 11, 2014, Inspector #573 observed that Resident #2 was sitting in a wheelchair with a table top. On the resident's wheelchair, both full length arm pads on the arm rest on the front side were observed to have no cushion or padding, this resulted

in the exposure of sharp metal edges on the corners of both the arm rest for about 3 inches and exposed pointed screws, approximately ½ inch on both the arm rests. It was also observed by the Inspector that resident #2 is constantly manuvering the table top, including removing the table top from the wheel chair and holding on to the edges of the arm rest.

On December 11 ,2014, Inspector #573 discussed the state of disrepair of the wheelchair and potential safety risk to the resident with both the RPN #S103 and PSW #S109. Both staff and the home's physiotherapist agreed that the disrepair to the resident's wheelchair posed a risk to the resident and that to date, no preventative measures have been put in place. The RPN and PSW, both stated that a request for assessment has been made to the motion specialist wheelchair technician and to the occupational therapist regarding the resident's table top and arm rest concerns on December 1, 2014.

Inspector #573 reviewed the resident health records and progress notes. Progress notes related to skin and wound indicates that on a recently specified date, the resident had bleeding on left forearm after bath and the progress notes also indicate the resident's agitation and restless behaviour while Resident #2 is seated in the wheel chair. There was no supporting evidence that the home has taken any preventative measures, since the identification of the disrepair on December 1, 2014, to address the potential risk to resident, to reduce or prevent any injury (skin tear) from the exposed metal edges and screws.

Inspector #573 spoke to home's physiotherapist regarding resident #2's wheelchair and safety risks. The physiotherapist stated that, prior to this inspection, she was not aware of the disrepair of the wheelchair and although, she has discussed the need for a seating assessment with the occupational therapist, no discussion has taken place regarding the disrepair.

On December 11 ,2014, after the Inspector identified of the risk to Resident #2 related to the disrepair of the wheelchair, Nursing Staff Coordinator #S100 and PSW #S109 applied a protected layer of cloth/foam padding with tape to both armrests to cover over the exposed metal edges and screws.

On December 17, 2014, Inspector #573 observed that both arm rests of Resident #2's wheelchair had been changed with a new set of arm rests.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

Findings/Faits saillants :

The licensee failed to ensure that a device used to assist a person with a routine activity of living (ADL) is used only if the use of the personal assistance services device (PASD) is included in the resident's plan of care.

Resident #9 was observed between December 8-11, 2014 to be seated in a geri-chair with table top applied at all meal services observed on the 2nd floor. At the end of the meal service the table top would be removed. Inspector #148 confirmed that the resident is unable to release the table top from the geri-chair. RN #S102 reported that the table top is used at meals as the resident is known to wander and will not always stay at to complete his/her meal, indicating that the table top is used to assist with the ADL of eating .

The plan of care for Resident #9 indicates the use of the geri-chair under items of aggression and wandering. The use of the geri-chair with table top is further noted as an intervention under the item of rummaging and hoarding; "use geri chair with table top PRN for agitation/aggressive wandering behaviours". The plan of care does not indicate the use of a table top as a PASD for Resident #9. In no other area of the health care record was the use of a table top as a PASD documented.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

The licensee failed to ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear.

On Tuesday, December 9, 2014, Resident #19 was observed at 9:30am seated in a wheelchair wearing a hospital gown, the resident's legs were bare and exposed, arms exposed and the back of the gown was open exposing the resident's upper back.

On Tuesday, December 16, 2014, Resident #19 was observed at 9:45am seated in a wheelchair wearing a hospital gown, in this instance the resident's legs were covered by a bed sheet, however, the back of the gown remained open exposing the resident's upper back. The resident was observed after 10:00am, after the provision of a bath, to be dressed in appropriate day time clothing.

Observations of the resident on December 10, 11 and 15, 2014, demonstrated that the resident was dressed in appropriate day time clothing in the morning hours.

On December 16, 2014, it was confirmed that Tuesdays are the regularly scheduled bath day for Resident #19. PSW #S109, reported to Inspector #148 that residents scheduled for a morning bath are allowed to stay in their nightwear until their bath, she further noted that Resident #19 does not have more than a hospital gown as night wear.

The plan of care for Resident #19 indicates that he/she requires total assistance with dressing with a goal to be appropriately dressed, the plan of care does not indicate that the resident does not prefer to be dressed on scheduled bath days. The resident was unable to express dressing preferences to the Inspector.

Resident #19 was not dressed appropriately, suitable to the time of day or in accordance with preferences on the observed scheduled bath days.

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a response in made in writing within 10 days of receiving Residents' Council advice related to concerns or recommendations.

On December 15, 2014, the Residents' Council Minutes for March 29th, 2014 up to October 31, 2014 were reviewed by Inspector #592. Concerns were identified and brought forward by the Resident Council on September 29, 2014 to have more active activities, including arts and crafts in the home. A written response by the Administrator on October 7th, 2014 indicated that the council had not expressed any concerns at the September 2014 meeting. Furthermore, concerns were brought forward by the Residents' Council on August 28th, 2014, to have bingo twice a week, preferably on Tuesday and Thursday, rather than Monday and Tuesday. A written response from the Administrator on September 2, 2014, indicated that the council had not expressed any concerns at the meeting in August.

During an interview with the Administrator on December 15, 2014, (acting assistant of the Residents' Council) he indicated to the Inspector that he is reading the Resident Council Minutes but did not respond to the concerns. The Administrator indicated that the concerns are resolved by each department who will make changes according to the concern/complaint voiced during the meeting. The Administrator further indicated that he is not aware of any response in writing from any of the other home managers related to the concerns that were brought forward by the council on September 28, 2014 and August 28, 2014.

The licensee is not responding in writing within 10 days of receiving the Residents' Council advice related concerns or recommendations. [s. 57. (2)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee did not ensure that the home's menu cycle is reviewed by the Residents' Council for the home.

Inspector #148 spoke with the Nutrition Manager who reported that the Fall/Winter menu, currently in place, was implemented in October 2014. He reported that the menu will be reviewed by the Residents' Council at the December meeting next week, now that the menu has run through a couple of cycles. The NM indicated that the Residents' Council was not provided an opportunity to review the menu prior to the implementation in October 2014.

Inspector #592 reviewed the meeting minutes of the Residents' Council for September and October 2014 and did not find evidence that the Residents' Council was provided an opportunity to review the home's current menu cycle. [s. 71. (1) (f)]

2. The licensee did not ensure that the planned menu items are offered and available at each meal and snack.

The meal service was observed on December 10, 2014. The planned dessert options, as posted, included a choice of pineapple or vanilla pudding. As observed for the puree texture modification, vanilla pudding was prepared, however, no puree pineapple was offered or available. Inspector #148 spoke with the Dietary Aid #S105 who indicated that those residents requiring a puree texture did not have a choice of dessert at this meal. She further reported that the residents do not like the fruit and if it is on the menu as the second choice dessert it is normally not prepared for the puree texture.

The meal service was observed December 15, 2014. The planned entrée, as posted, included a choice of spaghetti, broccoli and garlic bread or grilled cheese and spinach salad. As observed for the puree texture modification, the grilled cheese and spinach salad were not prepared. The dietary aid serving the meal, indicated that a tray puree would be provided to residents as the second choice entrée.

Upon further questioning it was determined that a chicken, pea and potato tray puree was available in the freezer but was not prepared. At the same meal service, the planned dessert included a choice of fruit or cake. As observed for the puree texture, cake was not available as planned, providing the puree fruit as the single choice for dessert for those resident's on the puree texture modification. [s. 71. (4)]

WN #15: 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:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee did not ensure that the home's dining service includes course by course service of meals for each resident, unless otherwise indicate by the resident or by the resident's assessed needs.

Inspector #148, observed the meal service on December 8, 2014. While consuming the entrée, four residents, Residents #9, #21, #22, #41, were observed to be provided the dessert course while consuming the entrée. There was no indication in the plan of care that residents required an intervention other than course by course service.

Inspector #148, observed the meal service on December 10, 2014. While consuming the entrée, two residents, Resident #15 and #9, were observed to be provided the dessert course while PSW staff members were providing physical feeding assistance with the entree. There was no indication in the plan of care for either resident to require an intervention other than course by course service.

The home's dining service does not include course by course service of meals to residents. [s. 73. (1) 8.]

2. The licensee failed to ensure that no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident.

The plan of care indicates that Resident #15, who is at high nutritional risk, requires total dependence for eating. The plan of care indicates that Resident #18 requires extensive assistance. The plan of care for indicates that Resident #41 requires extensive assistance.

The meal service was observed on December 8, 2014. At 12:10pm, three residents, Resident #15, #18 and Resident #41 were observed to have their soup and fluids. The residents were not observed to feed themselves during the observation time. Staff members became available and provided feeding assistance to Resident #15 at 12:15pm, Resident #18 at 12:16pm and Resident #41 at 12:22pm.

Three residents, requiring assistance with eating and/or drinking were served a meal prior to someone being available to provide the assistance required. [s. 73. (2) (b)]

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

Issued on this 23rd day of December, 2014

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) :	AMANDA NIXON (148), ANANDRAJ NATARAJAN (573), KATHLEEN SMID (161), MELANIE SARRAZIN (592)
Inspection No. / No de l'inspection :	2014_200148_0044
Log No. / Registre no:	O-001281-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 22, 2014
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 BOURGET 2279 Laval Street, P.O. Box 99, Bourget, ON, K0A-1E0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	~~GERRY MILLER~~ STEVEN GOLDEN

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:

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

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. 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall prepare and submit a plan to ensure written policy to minimize the restraining of resident is complied with and to ensure that any restraining that is necessary is done in accordance with the Act and the Regulations.

The plan, at a minimum, shall include:
-A complete audit of all resident's residing in the home to assess if a physical device, that limits/inhibits a resident's freedom of movement, from which the resident is both physically and cognitively unable to release themselves, is required. The audit will be used to determine if the application of any physical device is defined under section 31 or 33 of the Act.
-For those physical devices used to restrain a resident under section 31 of the Act, the plan shall ensure that all requirements of section 31 and section 109 of the Regulations is complied with.
-A quality monitoring program to ensure the home's compliance with the written policy to minimize the restraining of residents and that restraining that is necessary is done in accordance with the Act and Regulations.

The plan shall be submitted by January 7, 2015 in writing to Inspector Amanda Nixon by fax #613-569-9670. Compliance due date of March 2, 2015.

Grounds / Motifs :

1. The licensee failed to ensure that where the Act or 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 requires to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with.

In accordance with the LTCHA 2007, s.29 and O.Reg 79/10, s.109 the licensee shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations. Further to this section 109 of the Regulations describes the content, at minimum, to be included within the policy to minimize restraints.

In accordance with LTCHA 2007, s.30 and s.31, a resident is restrained by a physical device when the resident is not able to physically or cognitively remove the device, the device has been included in the plan of care which includes, but is not limited to, the significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained.

Upon request for the licensee's policy to minimize restraints, the home's Administrator identified the Safety Plan –Resident, policy effective September 2013.

The policy describes the following:
-Alternative approaches to the use of restraints, the use of Appendix A (Safety Plan Interventions) to ensure alternatives have been explored
- Consent to be obtained from resident or resident substitute decision maker if the resident is not capable to make a decision related to the restraint. The Resident Safety Plan is to be discussed, if discussed over the phone, a copy of the Resident Safety Plan must be mailed to them. Record of consent discussion will be recorded on Appendix B (Consent to Use of Restraint).
- Obtain an order from a physician or registered nurse in the extended class. The order must include the type of restraint, reason for restraint and duration of application. Restraints must be applied in accordance with instructions specified in the order.
- Physical restraints include, front closing lap belts, 10 lb closure clasps (seatbelts), rear closing lap belts, table trays used for other than eating or activation, geri-chairs and tilt chairs.
- Registered nursing staff must reassess the resident's condition and evaluate

effectiveness at least every 8 hours. A task will be added to the electronic medication administration record, whereby registered staff are to sign off at the start of shift, indicating the restraint has been assessed and whether the restraint is to be continued.
- Registered nursing staff much ensure that every use of a physical device to restrain a resident is fully documented in the resident's progress notes, including but not limited to, circumstances precipitating the application of the restraint, alternative considered and why the alternative were inappropriate, person who applied the device and the time of application, all assessments, reassessments, monitoring, release and repositioning , removal or discontinuance of the restraint.
- Each month the DON will host a multidisciplinary meeting on each resident with a physical restraining device, using Part A of this policy to review the Resident Safety Plan. This meeting is to be documented in the progress notes.

Resident #9 was observed between December 8-11, 2014 to be seated in a geri-chair with table top applied. At times the table top was applied at meals, released when the meal service was complete. At other times the resident was observed to be seated with a table top applied outside of meal service. Inspector #148 confirmed that the resident is unable to release the table top from the geri-chair.

Inspector #148 spoke with RN #S102 regarding the purpose of the table top. RN #S102 indicated that the table top is used at meals as the resident is known to wander and he will not always stay at the meals to complete his/her meal. On the following day, the Inspector spoke with RPN #S103, who confirmed the use of the geri-chair and table top as a personal assistive service device at meals. RPN #103 also reported that the resident will wander about the hallways and enter resident rooms, the resident will disturb other residents and some incidents have led to physical altercations. The resident will be placed in a chair with table top to inhibit the resident from wandering into resident rooms to rummage and hoard. RPN #103 also indicated that the resident may be placed in the chair with table top if he/she has been wandering for too long and appears tired. The chair and table top will be applied so that the resident will have rest periods to prevent falls. At the point in time the geri-chair and table top are used to limit/inhibit the residents movement for the purposes of safety, the table top is considered a restraint under section 31 of the Act.

The most recent Minimum Data Set assessment was reviewed. Although coding

of the MDS assessment indicates that no physical devices or restraints are used, the Resident Assessment Protocols confirm that the resident is placed in the geri-chair for short periods due to excessive wandering and high risk for falls. In addition, the geri-chair is used when the resident is wandering in and out of resident rooms rummaging and hoarding items.

The plan of care for Resident #9 indicates the use of the geri-chair under items of aggression and wandering. The use of the geri-chair with table top is further noted as an intervention under the item of rummaging and hoarding; "use geri chair with table top PRN for agitation/aggressive wandering behaviours".

The physician orders, for Resident #9, indicates on specified date; "Put resident in a jerry chair with table top as necessary for wandering and reassess after an hour". A physician order approximately 1 month later; "Geri chair QID for a maximum of 1 HR Also geri chair QID PRN x 1 hour". The current 3 month Medication Review, which discontinues all previous orders, indicates "Geri chair - use QID for maximum of 1 hour, Also QID PRN". As of December 10, 2014 no order from a physician or registered nurse in the extended class was in existence for the use of a geri-chair and table top for the purpose of restraining the resident related to significant risk to the resident or others.

A review of the health care record demonstrated the Safety Plan Interventions (Appendix A, as per the policy) to explore alternatives to restraining, was not completed at any time for Resident #9.

A review of the health care record demonstrates that the Consent Form (Appendix B, as per the policy), was initiated on a specified date and a verbal consent was received from the substitute decision maker (SDM) for Resident #9 for the use of a geri-chair PRN with tabletop and to assess after one hour for wandering to another resident's room. The Consent Form is incomplete and the progress note of the same date, does not support that a discussion of all aspects covered by the Consent Form were discussed, as per the home's policy.

A review of documentation maintained by staff, including Point of Care, indicated that there is no current task assigned to ensure that who has applied the device and the time of application, all assessments, reassessments, monitoring, release and repositioning and removal of the device are documented. The task, "Safety Intervention (seatbelt /table top) in place and in working order daily. HCA Every shift", has been added and is completed by PSW staff members. A task has not

been added to the electronic medication administration record, whereby registered staff are to sign off at the start of shift, indicating the restraint has been assessed and whether the restraint is to be continued. Progress notes by registered staff do not indicate all instances of application of the device or all required information, as per the home's policy.

Resident #15 was observed between December 8-11, 2014 to be seated in a wheelchair. At no time during the observations was the resident observed with a seat belt.

Upon review of the resident health care record during the Stage 1 process of the Resident Quality Inspection, the following physician order was in place "wheelchair with seatbelt". The current 3 month Medication Review, indicates "wheelchair with seatbelt for safety".

The plan of care for Resident #15 related to high risk for falls indicates the use of a seatbelt for fall prevention when in wheelchair.

On December 11, 2014, the Inspector spoke with PSW #S107, who is a regular staff member familiar with the care of Resident #15. Staff #S107, when asked about the use of a seatbelt, indicated that the resident does not use a seat belt but rather has a chair alarm. On the same date, the Inspector spoke with RN #S106, who when asked indicated that the resident uses a seat belt when in his/her wheelchair. When informed that the resident was not wearing a seatbelt and had not been seen with a seat belt over the last 3 days, he proceeded to examine the wheelchair. Upon examination it was confirmd that the wheelchair did not have a seat belt for use. The RN proceeded to confirm the physician order and inform the Physiotherapist and DOC of the lack of seat belt. On the afternoon of December 11, 2014, RN had indicated that he had reassessed the resident's need and determined that a seat belt was required due to the resident's lack of strength, inability to weight bear and lack of ability to reposition self. The resident is known to lean forward at times and may fall out of the wheelchair and injury self.

During the observation period of December 8-11, 2014 the Inspector did not observe the restraint to be applied as per the physician order.

A review of the health care record demonstrated the Safety Plan Interventions

(Appendix A, as per the policy) to explore alternatives to restraining, was not completed at any time for Resident #15.

A review of the health care record demonstrates that two Consent Forms (Appendix B, as per the policy), were initiated. The forms are incomplete, do not indicate a documented consent was obtained and do not include a date in which the forms were initiated. Two other Consent Forms noted from years past, both relate to the use of a lap belt for an interim period of time.

A review of documentation maintained by staff, including Point of Care, indicated that there is no current task assigned, to ensure that who has applied the device and the time of application, all assessments, reassessments, monitoring, release and repositioning and removal of the device are documented. A task has been added to the electronic medication administration record, whereby registered staff are to sign off at the start of shift, indicating the restraint has been assessed and whether the restraint is to be continued. The December 2014 medication administration record indicates that from December 1-10, 2014, registered staff have signed off that the restraint has been assessed at 0800, 1200 and 1700. This is contrary to observations made by the inspector from December 8-11, 2014, that the resident is not wearing a seat belt.

Resident #19 was observed from December 8-11, 2014 to be seated in a tilt wheelchair with lap belt applied. Inspector #148 confirmed the resident was not able to release the lap belt. At no time during the observations was the resident observed with a table top.

Staff #S105 indicated that Resident #19 is always wearing the lap belt when seated in the wheelchair. When asked by the Inspector, Staff #S105 indicated that the resident also has a table top in his room, but that this is rarely used. Staff #S105 reported that the table top is used for activities primarily.

The current physician order for Resident #19, includes "seatbelt and table top with tilt wheelchair for safety/prevent falls". A review of the December 2014 medication administration record indicates "seat belt or table top while in wheelchair (tilt) to prevent falls, table top/seatbelt restraint if needed for residents' safety, to prevent fall if applied reassess hourly."

The plan of care for Resident #19 was reviewed and indicates the use of a seat belt and/or table top restraint for prevention of falls and safety and uses

seatbelt/lap table for fall prevention when in wheelchair. The plan of care further describes that the resident is provided a chemical restraint.

Inspector spoke with the RAI Coordinator, who assists to maintain the plans of care, she reported that the resident was to have both the seat belt and table top in place.

A review of the health care record demonstrated the Safety Plan Interventions (Appendix A, as per the policy) to explore alternatives to restraining, was not completed at any time for Resident #19.

During the observation period of December 8-11, 2014, the Inspector did not observe the restraint to be applied as per the physician order.

The plan of care for Resident #19 indicates the use of chemical restraint, which is contrary to the home's policy. The policy indicates that the licensee does not condone the use of chemical restrains other than in emergent situations when immediate action is necessary to prevent serious bodily harm. To note, the Inspector reviewed the medication administrator record for Resident #19 and it does not appear that chemical restraining is used for this resident.

A review of the health care record demonstrates that two Consent Forms (Appendix B, as per the policy), were initiated over 1 year ago related to physical restraints. The forms indicate the use of a seatbelt or table top restraint if needed/required for behaviours/agitation to prevent falls/safety. The consents obtained are not accurate to the current physician order or current use of the physical devices.

A review of documentation maintained by staff, including Point of Care, indicated a current task is assigned to the Kardex, there is no task assigned, to ensure that who has applied the device and the time of application, all assessments, reassessments, monitoring, release and repositioning and removal of the device are documented. A task has been added to the electronic medication administration record, whereby registered staff are to sign off every hour, indicating that the restraints (including seatbelt or table top or bed rails) has been assessed and whether the restraint is to be continued. The documentation is unspecific to which physical restraint is applied at what hour of the day.

The home is not following the policy titled Safety Plan – Residents, which was

identified as the home's policy to minimize restraints. As demonstrated by the findings above, physical restraining has been included in the resident plan of care without assessment of alternatives to physical restraining, residents have not been provided physical devices for restraining as indicated by plan of care and/or physician order, the plan of care and/or physician orders have not provided clear direction to staff in the application of the physical restraints, consents have not been obtained using the process outlined by Appendix A of the policy and/or do not provide accurate information as to the use of the physical device. In addition, procedures to ensure required documentation is completed by respective staff members, is not put in place as per the home's policy. In addition, on December 11, 2014, the Inspector spoke with the DOC related to the policy requirement of monthly meetings to discuss physical restraining devices. The DOC, indicated that monthly multidisciplinary meetings have not been held for each resident with a physical device, including Resident #9, #15 or #19.
(148)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 02, 2015

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,

(a) cleaning of the home, including,

(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and

(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and

(iii) contact surfaces;

(c) removal and safe disposal of dry and wet garbage; and

(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Order / Ordre :

The Licensee shall ensure that procedures are developed and implemented to address incidents of lingering offensive odours on the 1st floor, including hallways, common areas and four residents shared bathrooms.

Grounds / Motifs :

1. The licensee failed to ensure that lingering offensive odours are addressed in resident home areas on the 1st floor, including common areas, hallways and residents shared bathrooms, despite routine cleaning.

The licensee has a history of non-compliance related to lingering offensive odors. Most recently, a Voluntary Plan of Corrective Action (VPC) was issued on

November 26, 2014 as a result of inspection #2014_198117_0023. Prior to this, there has been non-compliance issued to the home on the following dates: February 26, 2013 a Voluntary Plan of Correction was issued as a result of inspection # 2013_193150_0002 and on August 28th, 2012 a Voluntary Plan of Correction as a result of inspection # 2012_054133_0035.

Throughout the course of this inspection, lingering offensive odors were noted by Inspectors #161, #148, #573 and #592 pervasively in resident home areas on 1st Floor including hallways, lounge areas and Resident shared bathrooms.

On December 8 and 10, 2014, Inspector #573 noted strong offensive urine odour particularly in three identified residents shared bathrooms. It was also observed by the Inspector that the identified bathroom floor tiles were stained with dried urine spots around the toilet.

On December 12, 2014, at 13:34 hours Inspector #573 observed strong offensive urine odour in and identified resident shared bathroom.

On December 16, 2014, Inspector #573 spoke with housekeeping Staff #S121 who stated that he is aware of the lingering offensive odors in three identified shared resident bathroom. Staff #S121 informed Inspector that the housekeeping staff are assigned to clean those residents shared bathrooms more than once in a day and yet despite routine cleaning they remain odorous. Housekeeping Staff #S121 indicated that they use neutral disinfectant cleaning agent (R2A) which they use on other resident bathrooms and air fresheners on fabric (Fresh Face) to control the odour. Staff #S121 further stated that they do not have any specific products and other interventions in place to manage the incidents of lingering offensive odours in those identified shared bathrooms.

On December 16, 2014, at 15:08 hours, during a walk-about of the home with the Environmental Manager (EM), it was reported that a lingering offensive odor was present on the 1st floor hallway near two resident bedrooms. The EM agreed with the Inspector regarding the strong urine odour in one identified resident bathroom and stated that the resident bathroom requires a good cleaning.

The EM stated that for resident bathrooms, in two of the identified rooms, the strong urine odour is coming from underneath the toilet bowl gasket and floor tile. The EM stated to the Inspector that a work order is placed to change the

toilet bowl gasket and caulking around the toilet sink for both two identified bathrooms. The EM further stated that the home does not have any products other than disinfectant cleaning agents for managing incidents of lingering offensive odours in the home.

The EM informed the Inspector that the home manages odour control in the home by using disinfectant cleaning agents, air fresheners and by changing the toilet gaskets.

On December 12, 2014, Inspector #573 reviewed the home policy and procedure regarding odour control, while the odour control policy and procedure indicates how to control odour in the home, the home failed to address and manage incidents of lingering offensive odours, as identified in the resident home areas on the 1st Floor including hallways and residents shared bathrooms in identified rooms, during the course of this inspection.
(573)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 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.

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

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 22nd day of December, 2014

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : AMANDA NIXON

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