Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

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

Ottawa Service Area Office
347 Preston St 4th Floor
OTTAWA ON L1K 0E1
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston 4iém étage
OTTAWA ON L1K 0E1
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 22, 2015	2015_198117_0011	O-001527-15 & O-001740-15	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 BOURGET
2279 Laval Street P.O. Box 99 Bourget ON K0A 1E0

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

LYNE DUCHESNE (117)

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): May 5 and 6 2015

Please note that two complaint inspections, Logs # O-001527-15 and O-001740-15, were conducted during this inspection. It is also noted that this inspection is also linked to Inspection #2015-198117-0013, Log #O-002097-15.

During the course of the inspection, the inspector(s) spoke with the home's administrator, the Director of Care (DOC), a Registered Nurse (RN), a Registered Practical Nurse (RPN), several Personal Support Workers (PSWs), to an identified resident and their family member, to several non-urgent transportation agency staff members, to another long-term care home's administrator and one of their Registered Nurses. The Inspector also reviewed an identified resident's health care records and transfer documentation.

The following Inspection Protocols were used during this inspection:
Dignity, Choice and Privacy
Skin and Wound Care

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1.The licensee failed to ensure that the provision of the care set out in the plan of care is

documented. [Log #O-001740-15]

Resident #1 is identified as being at risk for skin breakdown due to decreased mobility and incontinence. Resident #1’s plan of care identifies that the resident requires assistance with all aspects of personal care and requires 1- 2 staff member assistance with transfers and repositioning. The plan does identify that staff are to “report any new openings to registered staff.”

On May 5 and 6, 2015, a review of Resident #1’s health care record was conducted. The chart indicates that the resident did have a skin tear to a lower leg in late December 2014. This was reported to registered nursing staff who cleansed the skin tear and applied a dressing. No other information was found in the resident’s chart in regards to any bruising or skin integrity issues. Inspector #117 spoke with unit PSW staff members S#101 S#102, S#103 and S#104 as well as to RPN S#105 and RN S#100 regarding Resident #1’s skin integrity status. All report that they do not recall Resident #1 having any skin tears or bruises prior to his/her transfer to another Long-Term Care (LTC) home, on a specified day in January 2015. All stated that if the resident did have a skin tear, this would have been reported and documented in the resident’s health care record.

Staff members RN S#100 and PSW S#104 provided care to the resident on the morning the specified day in January 2015. They stated that the resident was washed and dressed at the beginning of their shift and therefore did not see Resident #1’s legs. They reported to Inspector #117 that to their knowledge, they were not made aware of and did not see any skin breakdown or injuries to Resident #1’s lower legs prior to his/her transfer to another LTC home. The home’s Director of Care (DOC) stated to Inspector #117 that she did see the resident on the day of the transfer. The DOC stated that the resident was fully dressed and that she did not recall seeing any dressings or injuries or being informed of any skin integrity issues to Resident #1’s lower legs prior to the resident leaving the home.

On the specified day in January 2015, Resident #1 was transferred to another LTC home. Admission / transfer assessment documentation from the other LTC home indicate that Resident #1 had a skin tear to a lower leg covered by a dry dressing as well as several small bruises on both lower legs at the time of the resident’s admission / transfer to their LTC home.

On May 7 2015, the other LTC home’s Administrator/Director of Care and Registered Nurse S#107 stated to Inspector #117 that they were the ones who received and

admitted Resident #1 to their home on the specified day in January 2015. Both confirm that they observed the presence of a dry dressing and several bruises to the resident's lower legs at the time of the resident's admission. They report that they did not receive any information from the sending LTC home in regards to the resident's dressing and bruising to both lower legs. Inspector #117 reviewed resident transfer information and no information was found in the documentation related to any skin tear, dressing or bruising to the lower legs. On May 7 2015, Resident #1 stated to Inspector #117 that he/she did not recall having any skin tear, dressing or bruising to the lower legs on the day of his/her transfer to the new LTC home on the specified day in January 2015. Resident #1 did state that he/she does have fragile skin and that his/her legs do bruise easily.

On May 8, 2015, Inspector #117 spoke with the non-urgent transport driver who relocated Resident #1 from the one LTC home to the other LTC home. The driver stated that the resident was dressed and had his/her legs covered during the transfer and therefore did not see if the resident had any dressings or injuries. The driver confirmed that he did not apply any dressings to Resident #1's leg. The driver also stated that to his knowledge Resident #1 did not sustain any injuries during the transfer between LTC homes.

On May 8, 2015, Inspector #117 spoke with the Administrator of the sending LTC home regarding Resident #1's skin tear, dressing and bruising identified at the receiving LTC home. The Administrator stated that any skin injuries and wound interventions should have been documented in the resident's chart.

Nursing staff did not document the provision of care given to Resident #1 in regards to a lower leg skin tear and dressing and bruising to both lower legs. [s. 6. (9) 1.]

Issued on this 22nd day of May, 2015

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

Original report signed by the inspector.