Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
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
Aug 30, 2016	2016_200148_0029	013404-16	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), JOELLE TAILLEFER (211)

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): August 23-26, 2016

This inspection also included a critical incident report related to a missing resident and one complaint related to the provision of medication, compression bandages and alleged abuse.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Nursing (DON), RAI Coordinator, Registered Dietitian, Activity Director, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Food Service Workers (FSW), family members and residents.

In addition, the inspection team observed the home's environment including infection control practices, resident staff interactions, resident care, meal service and medication administration. The inspectors reviewed resident health care records including plans of care, fall and pain assessments in addition to review of relevant policies.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

3 WN(s)
1 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 O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to stairways are kept closed and locked.

On August 23, 2016, Inspector #211 observed the door leading to the stairway on the second floor of the resident's unit hallway, located near the Administration office, was not completely closed and locked. The door alarm was not audible. The door was equipped with a door access control system with an audible door alarm. When the door was pushed by Inspector #211, the alarm activated. An identified PSW arrived and cancelled the alarm at the point of activation beside the door. Signage was observed on the door which read "Close the door completely".

Interview with PSW #102 revealed that it was the first time that the door did not close completely.
Interview with the Administrator and observation of the identified door revealed the closing mechanism of the door closed rapidly and slammed loudly. However, the door mechanism did not engaged when the door was closed slowly.

Interview with the Administrator revealed that the auto door bracket placed on the top of the door needed to be repaired to prevent the door from closing loudly. The Administrator also revealed the door did not connect properly when the door was closed slowly; therefore preventing the locking mechanism to engage. The Administrator stated that he had been having some concerns with the door system for the past three weeks. The Administrator revealed that the home was aware of the problems with the door's locking mechanism. This was assessed by the home's maintenance department and the door was repaired. He was not aware of the new issues with the door.

On August 24, 2016, at 0945 hours, Inspector #211 pushed the same stairway door, without input of the key pad number. The door opened and the alarm activated.

Interview with the Administrator revealed the magnets between the door and the door frame were not touching enough thus preventing the door locking mechanism from working properly. The door should not open when being pushed open, without putting the numbers into the key pad.

On the above described occasions, the Inspector noted the stairwell door to not be fully closed and not locked. [s. 9. (1) 1. i.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure tat all doors leading to stairways are kept closed and locked, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1.The licensee has failed to ensure that there is a written plan of care for each resident that sets out, the planned care for the resident.

Resident #001 was admitted in the home in 2013, with several chronic health conditions that may contribute to pain management.

Interview with resident #001 revealed that he/she was having pain in an identified area. The resident explained that the pain was persistent and never really go away completely, even after taking pain medication. The pain was causing moderate discomfort.

Review of the resident's progress notes for March through to August 2016, indicated the resident complained of the pain on fifteen occasions. In addition, the resident stated that he/she had a recent fall and had hit his/her head. This fall was confirmed by the health care record.

Interview with PSW #114 revealed the resident has complained occasionally of thepain for the past two years. The resident's pain was reported to the nurses and pain medication will be given.

Interviews with RPN #103 and review of the resident's plan of care, revealed that the resident's current written plan of care does not include the planned care for resident #001 as it relates to ongoing pain and pain management.

Interview with the DON confirmed that the resident's written plan of care should include the planned care related to the resident's complaints of pain.

2. The licensee has failed to ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary.

Resident #001 reported having frequent and recurring pain in an identified area. In an interview with PSW #114, it was reported that the resident has been complaining of the pain for the past two years.

Interview with RPN #103 on August 25, 2016, stated that she was aware of the resident's pain. The resident is receiving an analgesic for the pain and the nurse documented the effectiveness of the pain medication in the progress notes. RPN #103 identified that the review of the resident's health care record shows that the quarterly assessments do not identify the resident's pain issue. RPN #103 indicated that the last pain assessment was completed on in 2014. The assessment did not include the resident's current area of pain.

The DON confirmed that even though the pain medication's effectiveness was documented in the resident's health care record, the nurse should complete a pain assessment in the Assessment Task to monitor resident's pain quarterly.

3. The licensee has failed to ensure that resident #018 was reassessed and the plan of care reviewed and revised when the care set out in the plan has not been effective.

Due to disease process and a stroke within the last year, resident #018 requires assistance with eating and has significant cognitive decline. The resident's weight history indicates that the resident's usual body weight was above ideal weight ranges, however, since at least December 2015 the resident's weight has been steadily declining.

Soon after the resident's stroke, the plan of care was reviewed and revised to include puree texture and the addition of 125ml of Instant breakfast at evening snack or when the meal is refused. A month later, the plan of care was revised to include that the resident required total feeding assistance.

Inspector #148 observed the resident at a lunch meal service. The resident was exhibiting verbal behaviours at the table and with the assistance of staff, only consumed bites of the meal and one glass of fluid. The Inspector spoke with a PSW responsible for the resident who indicated that the instant breakfast was not provided to the resident as the resident does not usually accept this drink when offered.

On August 26, 2016, the Inspector spoke with the home's Registered Dietitian who has been conducting quarterly reviews of the plan of care throughout 2016. The RD reported that it was after the resident's stroke, whereby the resident's health status declined and changes were made to the nutritional plan of care. She reported that it is primarily the resident's cognitive impairment and responsive behaviours that contributes to the resident's poor intake; she was aware of the resident's progressive and significant weight loss. The RD indicated that the resident should be provided instant breakfast when less than 50% of the meal is consumed. The RD was not aware of the staff implementing instant breakfast only when the meal was refused nor was she aware that the resident may not be accepting of the drink. Further to this, the RD confirmed that there have been no changes to the nutritional interventions since time time of the resident's stoke, despite the recorded weight loss.

The plan of care has not been reviewed and revised when the care set out in the plan has not been effective in the management of significant weight loss.

WN #3: 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:
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there is a process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

On a specified date in July 2016, the home's Registered Dietitian assessed resident #001 and indicated that the resident receives a therapeutic diet due to related health conditions. In review of the health care record, the Inspector noted that the resident has been assessed to receive the identified therapeutic diet, since at least 2013.

Upon observation of the servery, it was determined that there were two sources of dietary information available to food service workers. The first was a one page document developed primarily to assist staff in documenting the meal choice of a resident. This one page document included resident #001 to require a regular diet. The second source of information was a multiple page document filed in a black binder. This document indicated that resident #001 was required to receive the identified therapeutic diet.

On August 24, 2016, Inspector #148 observed the lunch meal service on the 2nd floor where resident #001 resides. When asked, FSW #108 indicated that resident #001 was on a regular diet and that there were no residents in the dining room requiring the identified therapeutic diet. At the time, the document being used by the FSW was the one page document indicating resident #001 required a regular diet. The black binder, with the correct information, was not in use and stored on a shelf near the microwave.

The identified therapeutic diet at lunch on August 24, 2016, was to include two ounces less than the regular portion of fish, the use of a smaller scoop size (#16 scoop) for the mashed potato and white bread/roll. The resident was provided the regular diet, including gravy and whole wheat bread. At this meal, the resident requested smaller portions and therefore received similar portion sizes similar to the planned therapeutic diet.

The process in place on August 24, 2016 did not ensure that the food service worker was aware of resident #001's dietary needs.

Issued on this 30th day of August, 2016

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

Original report signed by the inspector.