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

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Inspection de soins de longue durée

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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
Apr 3, 2017	2017_548592_0008	003070-17	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

MELANIE SARRAZIN (592), JOELLE TAILLEFER (211), LISA KLUKE (547)

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): March 20, 21, 22, 23, 24, 27, 28, 29 and 30, 2017

The following critical incident were inspected during the Inspection:
Log #: 028344-16 and Log # 006677-17 related to resident to resident physical abuse and Log # 033851-16, related to safe and secure home and emergency response system.

During the course of the inspection, the inspector(s) spoke with Residents, Family Members, a member of Residents' Council, Chair of Family Council, Personal Support Workers (PSW), Registered Nurses (RN), Registered Practical Nurses (RPN), a Dietary Aide, Housekeeping staff, Environmental Service Manager, Dietitian, Food Service Supervisor, Director of Activity (DOA), RAI MDS Coordinator, Administrative Assistant, Director of Nursing (DON) and the Administrator.

During the course of the inspection, the inspector(s) conducted a tour of the resident care areas, reviewed residents' health care records, relevant licensee policies and procedures, staff work routines, posted menus, observed resident rooms, resident common areas, the Admission process and Quality Improvement system, Residents' Council and Family Council minutes, a medication administration pass, one meal service, the delivery of resident care and services and staff to resident and resident to resident interactions.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
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
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

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

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

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

On March 20, 2017, Inspector #211 observed that residents #011 and #009's bed mattresses were sliding side to side on the bed frame and were not inserted into the bed frame keepers.

On March 23, 2017, Inspector #211 and RPN #120 observed that the mattresses for both resident #011 and #009 were improperly inserted into the bed frame keepers.

On March 23, 2017, Inspector #211 and PSW #114 observed that some of the bed mattresses were improperly inserted into their respective bed frame keepers namely: residents #009, #042, #043, #005, #007, #008, #011 and #044.

Review of the sheets titled "Maintenance requisition" identified by the ESM and found in the black binder on the first floor did not report that residents #011's and #009's bed mattresses were not stable on the frame.

Review of the home's sheets titled "Facility Entrapment Inspection Sheet" on January 2017, indicated that some of the beds identified with the old mattresses were changed and some of the beds identified with broken or missing mattress keepers were replaced. Residents #011 and #009 were not the identified beds indicated on the above sheets. The "Facility Entrapment Inspection Sheet" for February-March 2017, indicated resident #011's bed had a broken and missing keepers and resident #009 had a round old mattress.

Interview with the Environment Services Manager on March 23, 2017, revealed that both bed keepers at the head of the bed frame were broken and replaced on March 20, 2017 for resident #011's bed. The EMS indicated that the resident #009's mattress was old and the edge of the mattress were round preventing the mattress corners to stay inside the bed frame keepers. The EMS stated that the mattresses for both residents were replaced on March 20, 2017.

Interview with RPN #120 on March 23, 2017, acknowledged that residents #009 and #011's mattresses were not properly inserted inside the bed frame keepers and may potentially slide side to side. RPN stated that the staff should be reminded when the

residents' sheets are changed to ensure the four corners of the mattress are inserted properly inside the bed frame's keepers.

Interview with PSW #114 on March 23, 2017, acknowledged that the above residents 'mattresses were not properly inserted into the bed frame keepers and may potentially slide side to side and could result in a safety hazard. However, PSW #114 indicated that resident #011 preferred making his own bed and consequently could be a safety issue if the mattress is not properly inserted into the bed frame keepers.

Interview with the ESM and the DON stated that there is a process in the home to inform the maintenance staff to ensure that the home, furnishing and equipment are maintained in a safe condition and in a good state of repair.

The licensee has failed to ensure that the home's furnishing were maintained in a good stated of repair for resident #011 and maintained in a safe condition to prevent the resident's mattress to slide on the bed frames. [s. 15. (2) (c)]

2. The licensee has failed to ensure that the PASD used under section 33 of the LTCH Act 2007, for resident #014 was well maintained.

A PASD identified above in a specified room as two half bed rails used for resident #014 was noted on March 20, 2017 by Inspector #547 to be very loose on both sides of the resident's bed frame. Inspector #547 further noted that these bed rails were applied too far out from the resident's bed frame.

RN #116 indicated to Inspector #547 on March 23, 2017 that the two half bed rails were not noticed as a risk for resident #014 as the resident no longer moved very much.

PSW #114 indicated to Inspector #547 that she observed that the resident's bed rails were positioned farther away from the resident's bed frame for some reason, but she was not worried as the resident no longer moved independently when in bed. PSW #114 indicated that she was aware that if nursing staff noticed equipment like this that are loose or not properly positioned, that they should place a note in the maintenance book for the unit.

Inspector #547 reviewed the maintenance requisition forms for the resident's unit for a period of three months and noted that there was no documentation indicating loose or poorly fitted bed rail being identified for resident #014.

The DON indicated to Inspector #547 that the PSW's are expected to identify maintenance issues in the maintenance book on each unit. The Environmental Services Manager (ESM) indicated that resident #014's bed mattress keeper was positioned for some reason too wide for resident #014 mattress and that the resident's bed rails were loose. These issues were not identified in the maintenance log book for this unit for proper maintenance of these bed rails for resident #014 needs. [s. 15. (2) (c)]

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 bed keepers, mattresses and side rail are kept in a good state of repair, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to comply with O. Reg. 79/10 s. 17. (1) (g) in that every licensee of a long term care home shall ensure that the home is equipped with a resident-staff communication and response system that in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff.

In this report the resident-staff communication and response system is commonly referred to as the call bell system.

During observations of resident's rooms and common areas on March 20, 21 and 22, 2017, Inspector #592 noticed that the call bell sound on the second floor specifically for nine rooms located at the end of the North corridor were not audible when the call bell was activated.

It is to be noted that the speaker for the communication call bell system on the second floor is located at the nursing stations which is located in the middle of the two hallways. The communication call bell system is also connected and linked with the first floor.

On March 20, 2017 at 1420 hours, Inspector #592 activated the call bell in a specified room on North corridor and was unable to hear the call bell sound in the resident's room and in the hallway. PSW # 102 who was walking by was asked about the call bell sound. She indicated to the Inspector that the call bell sound was not audible unless she was near the nursing station and that she relies on the door light outside of the resident's bedroom. PSW #102 further indicated that she came to the room because she was close to the nursing station where the call bell panel is located, otherwise she would of not be able to hear it. She further indicated that the call bell volume was higher in the past but had been lowered by the nurses in order for them to be able to have a conversation on the phone when requiring to contact specific resources. She further told the Inspector that she does not hear the call bells when she is in a resident room specifically from half of the North hallway to the end where nine rooms are located.

On March 20, 2017 at 1510 hours, Inspector #592 activated the call bell in another specified room on North corridor and was unable to hear the call bell sound in the resident's room and in the hallway. While conducting observation of the room, Inspector #592 who was attempting to listen to the call bell sound was told by HKP #101 who was nearby that the call bell was not audible at this end of the hallway, but if the Inspector would go closer to the front nursing desk she would be able to hear the sound.

On March 21, 2017 at 0845 hours, Inspector #592 activated the call bell in two specified

rooms on North corridor and was unable to hear the call bell sound in the resident's room and in the hallway. Inspector #592 activated the call bell a second time with the presence of RPN #100. RPN #100 indicated that he was not able to hear the call bell when present in the resident's room or the hallway but that it was at the request of the resident's in order to not be disturbed. He further indicated that often the staff are relying on the dome light outside of the resident's rooms specifically for the rooms located at the end of the North hallway.

On March 23, 2017 at 1140 hours, Inspector #592 activated the call bell in a specified room on North corridor with the presence of the ESM. The ESM indicated that the call bell sound was not audible in the resident's room and noted upon a walk through with the Inspector that the call bell sound in the North corridor was not audible from room the middle of the hallway to the end when activated. He further indicated to the Inspector that he was not aware about any changes to the communication system and not aware that the communication system was available to the staff for them to decrease or increase the sound level.

During the interview with the Administrator on the same day, he indicated upon activating the call bell in a specified room, that he was not able to hear the call bell sound. He further indicated that there was no access to the communication system to calibrate the sound level. The Administrator spoke with RPN # 112 who indicated that she was not aware how to calibrate the sound of the communication system and if needed to do so, she would contact her Manager. The Administrator indicated that he was not aware that the call bell system was not well calibrated as it was not triggered while conducting the home's call bell audits. He further indicated that after reviewing the communication system, there was no access to calibrate the sound level but would notify the licensee.

During the interview with the Administrator on March 30, 2017, he indicated that he has contacted an outside vendor to come to the home to calibrate the resident-staff communication and response system on the North corridor and that in the meantime, the staff were made aware to increase visual checks of the door light outside of the resident's bedroom and also for staff located on the first floor to monitor the resident-staff communication and response system for activation on the second floor to ensure that the call bells are responded in a timely manner. [s. 17. (1) (g)]

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 resident-staff communication and response system is properly calibrated at the end of the North corridor, to be implemented voluntarily.

WN #3: 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. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

1. The licensee has failed to seek the advice of the Residents' Council in developing and carrying out the satisfaction survey.

On March 22, 2017, during an interview, Inspector #592 spoke with the Residents' Council President who indicated that he/she was unsure if the licensee had seeked the advice of the Residents' Council when developing and carrying out the survey as he/she was new to his role.

On March 22, 2017, during an interview, Inspector #592 spoke with the Director of Activity who is the appointed assistant to the Resident's Council who indicated that she did not seek the advice of the Residents' Council in developing and carrying out the satisfaction survey this year, as it was generated through a survey on line for all the resident's and the family members. [s. 85. (3)]

2. The licensee has failed to seek the advice of the Family Council in developing and carrying out the satisfaction survey.

On March 28, 2017, during an interview, Inspector #592 spoke with the Family Council Representative who indicated that the satisfaction survey was distributed in January 2017 without seeking the advice from the family members. The Family Council Representative indicated that the family members were not consulted for the development of the satisfaction survey as before. She also indicated to the Inspector that usually the licensee consult with them but this year they were told it would be done differently without seeking for their advice. She also indicated that the family members have expressed their concerns to the Administrator during the family council meeting which took place on March 27, 2017.

On March 22, 2017, during an interview, Inspector #592 spoke with the Administrator who indicated that the home did not seek the advice of the Residents' and the Family Council in developing and carrying out the satisfaction survey in 2016. He further indicated that the home has received a new standardized survey released by inteRAI to be used for this year from the licensee for the residents and families to be completed on line. The Administrator further indicated that this survey was for future reference in order to have the next annual satisfaction survey more individualized and to identified individual needs of the home. [s. 85. (3)]

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 licensee seeks the advise of the Resident and the Family Council when developing and carrying out the satisfaction survey, to be implemented voluntarily.

WN #4: 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:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. 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 non-residential areas must be equipped with locks to restrict unsupervised access to those areas by the residents, and those doors must be kept closed and locked when they are not being supervised by staff

During the initial tour on March 20, 2017, Inspector #211 observed an unlocked and unsupervised storage room on the West Wing area of the 1st floor in front of the home's front entrance. The storage room contained two electric floor buffer machines and one electric floor vacuum. Moreover, the door was lockable from the inside. The inspector noticed that the storage room was accessible to the unsupervised residents walking in the area and one resident was sitting beside the front entrance.

On March 22, 2017, Inspector #211 observed the above unsupervised storage room slightly opened and unlocked.

Interview with the Director of Nursing (DON) on March 20, 2017, revealed that the above storage room door should be kept closed and locked at all times.

Interviews with the housekeeper staff #106, and the Environment Services Manager (ESM) on March 22, 2017, revealed that the storage room should be kept closed and locked at all times since the room contained electric machines that may potentially constitute a fall hazard for a resident entering the area.

Interviews with the housekeeper staff #107 and the ESM on March 22, 2017, revealed that the storage room should be kept closed and locked at all times since the door can be locked from inside and may constitute a hazard as a resident may become trapped inside.

The licensee has failed to ensure that the storage door leading to a non-residential area on the first floor in front of the home entrance was kept closed and locked when the area was not supervised by staff. [s. 9. (1) 2.]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 111. Requirements relating to the use of a PASD

Specifically failed to comply with the following:

s. 111. (1) Every licensee of a long-term care home shall ensure that a PASD used under section 33 of the Act to assist a resident with a routine activity of living is removed as soon as it is no longer required to provide such assistance, unless the resident requests that it be retained. O. Reg. 79/10, s. 111. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the PASD used to assist the resident with a routine activity of living such as bed rails, was removed as soon as they were no longer required to provide such assistance, unless the resident requests that it be retained.

Resident #014 was observed by Inspector #547 on March 20, 2017 at 1400 hours in bed with two half rails applied and engaged. These half rails were located at the mid-point of the bed for this resident.

Resident #014's health care records reviewed by Inspector #547 and the plan of care had documented that the resident required two half rails in bed as a Personal Assistance Services Device (PASD). The purpose of this PASD, indicated to allow resident#014 to successfully utilize these bed rails to assist the resident with Activities of Daily Living (ADL).

PSW #114 indicated to Inspector #547 on March 23, 2017 that resident #014 does not usually move very much in bed anymore and no longer used the bed rails for activities of daily living. RN #116 indicated to Inspector #547 that resident #014 used the bed rails on his/her bed when he/she was more alert and that now he/she is no longer moving on his/her own.

The Director of Nursing (DON) indicated to Inspector #547 that resident #014 no longer moves in bed or has the capacity to use the bed rails for his/her activities of daily living and likely did not require the bedrails as a PASD anymore. [s. 111. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

On March 2017, Inspector #211 observed the vaccine refrigerator located in the office room titled "RAI Coordinator and Food Nutrition Manager" of the second floor. The vaccine refrigerator contained the following medications:
2 boxes of 1 kit, unopened inject syringeful intramuscuscularly Risperdal Constal 50mg/vial powder for injectable prolonged-released suspension for resident #030,
4 vials of unused NovoMix 30 Penfill for resident #040,
3 vials of unused Novomix 30 100 iu/ml for resident #011,
1 syringe of unused Prolia Denosumab for resident #038,
3 vials of unused Novorapid 100ui/ml injectable for resident #044,
3 pen with vials of unused Insuline Glargine (Lantus) inject for resident #044
9 vials of Pneumovax 23
3 boxes of one vial of Tubersol Tuberculin Purified Protein Derivative (mantoux 5 TU),
4 boxes of 10 doses of Fluviral Influenza vaccine Trivalent, inactivated Split-viron Fluad,
1 box of 5 doses pre-filled syringes Influenza virus Vaccine, surface Antigen, inactivated Adjuvanted with MF59C.1,
1 box of 10 doses of pre-filled syringes Influenza virus Vaccine, surface Antigen,

inactivated Adjuvanted with MF59C.1,
1 box of 3 vials of Td Adsorbed Tetanus and Diphtheria Toxoids Adsorbed,
1 box of 5 vials of Td Adsorbed Tetanus and Diphtheria Toxoids Adsorbed,
1 box of unopened of Prevnar 13 Pneumococcal 13-valent Conjugate Vaccine (Dephteria CRM 197 Protein).

Interview with RN #124 and the Resident Assessment Instrument Coordinator (RAI Coordinator)/RPN #125 on March 27, 2017, revealed that the office is shared and occupied by the RAI coordinator, the Food Nutritional Manager and the Registered Dietician.

Interview with the RAI Coordinator/RPN #125 on March 27, 2017, indicated that the Food Nutritional Manager and the Registered Dietician may use the office without the presence of a nurse.

Interview with the DON on March 27, 2017, acknowledged that the office is shared and occupied by the Nutritional Manager and the Registered Dietician. After interview with the DON on March 27, 2017, Inspector #211 observed that the vaccine refrigerator was re-located in the medication room.

The licensee has failed to ensure that all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator. [s. 130. 2.]

Issued on this 3rd day of April, 2017

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

Original report signed by the inspector.