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

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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 7, 2015	2015_384161_0019	O-002654-15	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 COBDEN
12 WREN DRIVE P.O. BOX 430 COBDEN ON K0J 1K0

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

KATHLEEN SMID (161), JOANNE HENRIE (550), MEGAN MACPHAIL (551)

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): October 13-16, 2015 and October 19-21, 2015.

This Resident Quality Inspection also included four additional inspections.

During the course of the inspection, the inspector(s) spoke with Residents, Family Members, President of Residents' Council, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), RAI Co-ordinator, 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 the Admission Process, Infection Prevention and Control as well as the Quality Improvement & Required Programs checklists, Residents' health care records, home policies and procedures, staff work routines, posted menus, Resident Council minutes. The inspector(s) observed Resident rooms, observed Resident common areas, observed the administration of medication, observed a meal service and observed the delivery of Resident care and services.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home

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 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:

* equipped with locks to restrict unsupervised access to those areas by residents, and
* locked when they are not being supervised by staff

During the initial tour of the home on October 13, 2015, Inspector #550 observed that the linen rooms on unit 1 and 2 were not locked. They are not equipped with any locks or a call bell system.

Inspector #550 observed the door to the staff washroom behind the nursing station on unit 2 was not locked when not in use and the washroom was not equipped with a resident staff communication system. This washroom was accessible by anyone.

Next to the hairdresser salon, there were two glass doors leading to the service hallway. These doors are not equipped with any locking mechanism and some days they were observed to be closed but not locked and other days they were observed open, giving access to anyone wishing to enter this part of the home.

During an interview, the Administrator defined the linen closets, the staff washroom behind the nursing station on unit 2 and the service area hallway to be non residential areas of the home and indicated these areas are not supervised by staff all the time. She further indicated there is no reason the residents of the home need to access the service area hallway. [s. 9. (1) 2.]

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 all doors leading to non-residential areas are equipped with locks to restrict unsupervised access to those areas by residents, and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that Resident #042 was protected from neglect by staff.

For the purpose of the Long-Term Care Homes Act, 2007 and Ontario Regulation 79/10, neglect is defined as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

On an identified date in January 2015 during the evening shift, Resident #042 was put on the commode beside his/her bed. Resident #042 required the assistance of two staff members, PSW #108 and PSW #110, and a mechanical lift to be placed on that commode.

At the time of the incident the resident's Cognitive Performance Scale score was 5 (severe impairment) and her Communication Scale score was 5 (rarely or never understands/makes self-understood).

PSWs, S#106, S#105 and S#103 were interviewed and stated that the resident required total assistance for all aspects of care. PSW, S#106 stated that Resident #042 could not activate the call bell to signal that help was required.

In the care plan in effect at the time of the incident, Resident #042 was at high risk for falls and required extensive assistance for toileting and total dependence for mobility.

RN, S #107 who worked the night shift on the identified date in January 2015 was interviewed, and stated that initial rounds were conducted at the start of that night shift which began at 10:30 p.m. According to the RN, PSW, S #109 came to her, and stated that she needed help to put Resident #042 into bed because the resident was found sitting on a commode beside his/her bed.

The RN stated that the oncoming night shift was not informed by the departing evening shift, that Resident #042 had been placed on the commode at approximately 7:30 p.m.

The RN stated that she assessed the resident and there was no injury or harm, and that her priority was to get the resident into bed and make the resident comfortable. The following morning, she emailed the DON regarding the incident and also informed the oncoming day shift staff of the incident that had occurred.

The DON was interviewed and stated that PSW, S #108 was assigned to provide care to Resident #042 on the evening shift of the identified date in January 2015.

According to the home's internal investigation notes, Resident #042's evening medications were given by the RPN at approximately 7:30 p.m. and the RPN did not perform any further checks on the resident during that evening shift. The home's internal investigation notes indicate that PSW, S #108 stated that that she had forgotten to remove Resident #042 from the commode, and that as the resident does not receive an evening snack or require toileting once in bed, visual checks were not performed during the remainder of the evening shift.

Resident #042 was left unattended on the commode for a period of time of approximately three hours which put the resident's safety at risk. [000857-15] [s. 19. (1)]

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 shift to shift communication protocols are followed as well as regular rounds of the residents including a final round at the end of each shift, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area that is secure and locked.

On October 13, 2015, during the initial tour of the home, Inspector #550 observed that the storage room next to DON's office was unlocked. Inside the storage room there were dressing supplies, briefs, resident hygiene products and inside an unlocked shelved cabinet that contained the government stock medication for the home. The Administrator walked by and indicated to Inspector #550 that she had noticed the door was unlocked and that it should be kept locked at all times.

The DON indicated to Inspector #550 she had discussed with the Administrator that they need to change the locking mechanism on the door to the medication storage room as the current lock does not lock on its own; someone has to physically lock it when they leave the room.

On October 14 and 20, 2015, Inspectors #550 and #551 observed Resident #011 had 1 bottle of Calcium Carbonate 5000mg (Tums) on their dresser and another one on their beside table. Resident #004 had a tube of Voltaren cream on their beside table.

The DON indicated to Inspector #550 both resident #004 and #011 are not permitted to keep any medication at their bedside and that it is the resident's family who brings in these medication. [s. 129. (1) (a)]

2. The licensee has failed to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

Inspector #550 observed inside the medication room there were 2 small refrigerators one on top of the other and both of them were not locked. The top refrigerator was labeled "medication". Inside the refrigerator the inspector observed on a tray vials of Lorazepam labeled as follows:

"emergency use", Lorazepam 4mg/ml 1 vial
Barrie Davies, Lorazepam 4mg/ml 1 vial
Peter Lindy, Lorazepam 4mg/ml 1 vial.

RN staff #S101 indicated to Inspector #550 that these medication are controlled substances and she is aware that controlled substances have to be kept double locked but these need to be refrigerated therefore they cannot keep them in the medication cart with all the other controlled substances. They have to keep them in the refrigerator and the refrigerator does not lock.

During an interview, the DON indicated to Inspector #550 she was unaware that narcotics and controlled substances that were not kept in the medication cart needed to be kept double locked within a locked area of the home. She indicated she did not know how to achieve this with controlled substances that need to be refrigerated. [s. 129. (1) (b)]

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 drugs are stored in an area or a medication cart that is secure and locked and that controlled substances are stored in a separate, double locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

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

The home's policy titled Abuse & Neglect – Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff, effective date August 2014 was provided by the Administrator.

On page 5/10, the policy states all cases of suspected or actual abuse must be reported immediately in written form to the DON/Administrator. In the absence of management staff, concerns should be reported immediately to the Charge Nurse, who will notify

management staff on call. Specific expectations for documentation are listed.

According to the Critical Incident Report (CIR), on an identified date in January 2015 at approximately 7:30 p.m. on the evening shift, Resident #042 was put on the commode and was left unattended. The resident was found on the commode beside his/her bed by a night staff member after 11:30 p.m. In the care plan in effect at the time of the incident, Resident #042 was at high risk for falls and required extensive assistance for toileting.

In an interview with RN, S #107, she indicated that after being found unattended on the commode, Resident #042 was put to bed and made comfortable. The manager on call was not notified of the incident. RN, S #107 stated that the following morning, she communicated the incident at the shift change report and sent an email to the DON.

In an interview with the DON, she indicated that, in the absence of management in the home, any suspicion of abuse or neglect of a resident should be reported by the Charge Nurse/RN to the manager on call who would know the next steps to follow.

On page 6/10, the policy states The person who has reasonable grounds to suspect that b) abuse of a resident by anyone, or neglect of a resident by the home or its staff, that resulted in harm or a risk of harm to the resident, has occurred or may occur must immediately report that suspicion and the information upon which it is based to the Director appointed by the Ministry of Health and Long Term Care.

The Director was not notified of the incident until two days later on January 13, 2015 when a CIR was submitted. [s. 20. (1)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who has reasonable grounds to suspect that neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident was immediately reported to the Director.

Resident #402 has resided at the home since 2011. According to the MDS assessment completed in January 2015, the resident had a Cognitve Performance Score of 5.

According to the Critical Incident Report (CIR), on an identified date in January 2015 at approximately 7:30 p.m. of the evening shift, Resident #042 was put on the commode with the assistance of two staff members.

In the care plan in effect at the time of the incident, Resident #042 was at high risk for falls and required extensive assistance for toileting.

RN, S #107 was interviewed and stated that on the identified date in January 2015, upon initial night shift rounds (night shift commenced at 10:30 p.m, PSW, S #109, came to her and stated that she needed help to put Resident #042 into bed because the resident was found sitting on a commode beside the his/her bed.

RN, S#107 stated that Resident #042 being left on the commode, unattended for a period of time, greater than three hours, constituted neglect.

The following morning after the identified date in January 2105, the RN reported the incident to the DON in an email. The DON was interviewed and stated that upon becoming aware of the incident, which constituted suspected neglect of a resident by staff that resulted in a risk of harm to the resident, an investigation commenced.

The Director was not notified of the incident until two days later when a Critical Incident Report was submitted. [s. 24. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident.

On October 14th and 20th, 2015, Inspectors #550 and #551 observed the following:

Resident #004: 1 tube of Voltaren cream was observed one time on the resident's bedside table and another time on the counter in the resident's washroom. The resident indicated to inspector #550 that staff administers the cream but the resident always keeps it in his/her room.

Resident #011: a bottle of Vitamin C on the resident's bedside table.

The Director of Nursing indicated to Inspector #550 that resident #004 should not have the Voltaren cream in his/her possession as the resident does not have a physician order for it and resident #011 is not supposed to self administer or keep any medication at their bedside.

Resident #004 indicated to Inspector #550 that the staff apply the Voltaren cream when the resident needs it. PSW staff #S104 indicated to the inspector, that staff including herself, apply the Voltaren cream to the resident when the resident requests it.

Resident #011 indicated to Inspector #550 that she/he self administers the Vitamin C on a daily basis and keeps it in her/his room.

Inspector #550 reviewed the health records for both residents and was unable to find a physician's order for resident #004's Voltaren cream and resident #011's Vitamin C tabs. [s. 131. (1)]

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Issued on this 7th day of December, 2015

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

Original report signed by the inspector.