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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 30, 2017	2017_658178_0018	024652-17	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 COBDEN
12 WREN DRIVE P.O. BOX 430 COBDEN ON K0J 1K0

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

SUSAN LUI (178), KATHLEEN SMID (161)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): November 14, 15, 16, 17, 20, 21, 22, 23, 24, 27, 28, 2017.

The following Critical Incident Logs were inspected as part of this RQI inspection:
003757-17, related to alleged resident to resident sexual abuse
008847-17, related to medications not administered as directed
025363-17, related to alleged neglect.
The following Complaint Log was inspected as part of this RQI:
010456-17, related to concerns regarding management of a resident's falls prevention, drug regimes, and weight changes.

During the course of the inspection, the inspector(s) spoke with residents, family members, the President of Residents' Council, personal support workers (PSWs), Physiotherapy Assistant, registered practical nurses (RPNs), registered nurses (RNs), Resident Assessment Instrument Coordinator, Geriatric Psychiatric Resource Nurse, Food Nutrition Manager, Activity Director, Environmental Services Manager, Administrator.

During the course of the inspection, the inspectors also toured the home, and observed resident care being provided, medication administration passes and infection prevention and control practices. The inspectors reviewed resident health care records, employee training documents, home policies and procedures, and the Residents' Council meeting minutes. The inspectors reviewed documentation related to the home's investigations into the above critical incidents.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care

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

- **4 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. 6. Plan of care

Specifically failed to comply with the following:

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 :

1. The licensee has failed to ensure that the care set out in resident #027's plan of care was provided to resident #027 as specified in the plan.

Resident #027 was admitted to the home with several diagnoses.

Review of resident #027's medical record by inspector #178 indicated that the resident was at high risk for falls, and experienced frequent falls. Many fall prevention interventions were tried but found to be ineffective, and on an identified date, the use of an identified physical restraint was introduced for resident #027 in an effort to prevent further falls. Review of the resident's toileting plan of care indicated that two days after the physical restraint was introduced, an intervention was added to the plan of care stating that the resident was not to be left unattended while on the toilet.

Review of resident #027's progress notes indicated that on the evening shift on a date approximately three weeks after the resident's plan of care had been revised to indicate that the resident was not to be left unattended on the toilet, the resident was found lying on his/her back on the floor of the resident's washroom, after being put on the toilet and left unattended. The progress note indicated that the resident stated that he/she was trying to get up to pull the call bell. The call bell was noted to be ringing at the time of the fall. The resident was assessed by registered staff and the physician, and appeared to be uninjured. The resident continued to be monitored for symptoms of a head injury.

During an interview with inspector #178 on November 27, 2017, RPN #104 indicated that she was working on the evening of May 24, 2017, and that an identified physical restraint was in use for resident #027 at this time, so staff would need to remove the restraint and assist the resident to transfer to the toilet. RPN #104 further indicated that the resident's plan of care stated that the resident should not be left unattended when on the toilet, and that there was a sign posted in the resident's washroom indicating this fact. RPN #104 indicated that on May 24, 2017, PSW #112 assisted resident #027 onto the toilet, and then left the resident unattended on the toilet, and the resident fell in the washroom. RPN #104 indicated that PSW #112 told her at the time that she was unaware that the resident could not be left alone while on the toilet, in spite of the fact that there was a sign posted in the washroom. RPN #104 further indicated that the fact that the resident required a physical restraint to prevent falls as a result of self transferring, should have made it clear that the resident should not be left alone on the toilet.

On November 28, 2017, inspector #178 interviewed PSW #114. The PSW was unable to recall any specifics regarding resident #027's fall in the washroom which occurred on an identified date, but indicated that she would not normally leave a resident who is at high risk for falls unattended on the toilet.

In conclusion, the licensee has failed to ensure that the care set out resident #027's plan of care was provided to resident #027 as specified in the plan.

(010456-17) [s. 6. (7)]

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 care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting resident #001.

An identified Critical Incident Report (CIR), which was submitted to the MOHLTC by the licensee, indicated that on an identified date, resident #001 reported to staff that while in the bathroom that evening, PSW #105 was present but failed to provide the resident with assistance to transfer off the toilet. As a result of the failure to assist, the resident fell to the floor. The resident experienced bruising and mild discomfort as a result of the fall, and the discomfort was controllable with analgesics.

Review of resident #001's health record, indicated that the resident has identified weakness, and requires assistance with toileting and transfers. The resident's plan of care in place at the time of the fall incident indicated that the resident required extensive assistance of one staff for transferring from one position to another.

On November 22, 2017, resident #001 indicated to Inspector #178 that on an identified date, the resident rang for assistance to be transferred off the toilet. PSW #105

answered the bell, but did not assist the resident to transfer from the toilet. Resident #001 indicated that PSW #105 "stood and watched" the resident attempt to transfer from the toilet, and did not provide assistance. The resident indicated that the resident used the grab rail to stand, but then fell. The resident indicated that PSW #105 was within reach of the resident during the transfer, but did not touch or assist the resident during the transfer.

On November 21, 2017, PSW #105 indicated to Inspector #178 that on an identified date, when she was assisting resident #001 to transfer from toilet, the resident's leg gave out and the resident fell. PSW #105 indicated that she assisted the resident by helping the resident to pull up clothing, and by helping the resident to stand up. The PSW indicated that when she reached around to grab the wheelchair so the resident could sit, the resident fell. PSW #105 indicated that she had her hands on the resident to provide assistance prior to the fall, but not at the time of the fall. When asked specifically how she assisted the resident to stand up, PSW #105 indicated that she did so by guiding the resident with her hand on the resident's back, and by helping the resident turn to the grab rail so that the resident was standing up straighter. PSW #105 indicated that when the resident fell, she was approximately a half a metre away from the resident. PSW #105 indicated that resident #001's plan of care at the time said that the resident needed one person assist to transfer, and that she provided assistance, but she could have provided a bit more, because the resident has identified weakness.

On November 21, 2017, the home's Administrator indicated to Inspector #178 that an investigation was conducted into resident #001's allegation that the resident was not assisted in the washroom by PSW #105 on an identified date, and as a result the resident fell. The Administrator indicated that the investigation concluded that PSW #105 did not provide sufficient physical support to resident #001, based on where the PSW was standing in the washroom. As a result of the investigation, PSW #105 received discipline, and re-education regarding the home's policy of zero tolerance of abuse and neglect.

On November 22, 2017, the home's Resident Assessment Instrument (RAI) Coordinator indicated that at the time of resident #001's fall in the washroom, the resident's plan of care called for extensive assistance from one staff member.

(025363-17) [s. 36.]

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 staff use safe transferring and positioning devices or techniques when assisting resident #001, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident is reported to the resident, the resident's substitute decision maker (SDM), if any, and the resident's attending physician.

As part of the Resident Quality Inspection, the home's documentation regarding medication incidents was reviewed, and three recent medication incidents were inspected. The inspection revealed that in two of the three recent medication incidents, the required notifications were not carried out.

1) Review of the home's medication incident reports for the last quarter indicated that a medication incident involving resident #023 occurred on an identified date. It was reported that on this evening, the resident was not provided with an identified medication

as ordered. The incident was discovered the following morning, when the evening medication was found to be still present in the medication cart. The resident was assessed to have suffered no ill effects as a result of the error. Review of the home's record of the incident did not indicate that the resident or the resident's substitute decision maker (SDM) was notified of the incident. Furthermore, there was no indication that the resident's physician was notified of the medication error.

During an interview with Inspector #178 on November 16, 2017, the home's Administrator indicated that resident #023 suffers from cognitive impairment and therefore has an SDM. The Administrator indicated that she could find no evidence to indicate that resident #023's SDM or the resident's physician had been notified of the medication error which occurred on the identified date. The Administrator indicated that it is the home's policy that when a medication incident involving a resident occurs, the resident or their SDM, the physician, the medical director, and the pharmacy provider are all notified.

2) Review of the home's medication incident reports for the last quarter indicated that a medication incident involving resident #024 occurred on an identified date. It was reported that on this date the resident was administered two doses of the same medication in error. The resident was assessed to have suffered no ill effects as a result of the error. Review of the home's record of the incident did not indicate that the resident or the resident's SDM was notified of the incident.

During an interview with Inspector #178 on November 16, 2017, the home's Administrator indicated that resident #024 is cognitively impaired, and therefore has an SDM. The Administrator indicated that she could find no evidence to indicate that resident #024's SDM had been notified of the medication error which occurred on the identified date. [s. 135. (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 every medication incident involving a resident is reported to the resident, the resident's SDM, if any, and the resident's attending physician, to be implemented voluntarily.

WN #4: 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 :

The licensee has failed to ensure that the bed systems for two identified residents, both of which include bed rails, were evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices, to minimize risk to the residents.

On November 14, 2017, Inspector #178 observed that the bed system for an identified resident included two partial side rails positioned in the middle of the bed. The home's Environmental Services Manager (ESM) was present, and indicated that this particular bed was not owned by the home. The ESM indicated that because the identified resident 's bed was not owned by the home, it had not been evaluated for risks of entrapment. During an interview with Inspector #178 on November 15, 2017, the ESM further indicated that when the identified resident was admitted to the LTCH, the resident was offered and declined a bed system provided by the LTCH. The ESM indicated that a

second identified resident was also using a bed not owned by the home, and that the second identified resident's bed had also not been tested for entrapment risk. The ESM indicated that he tests all of the home's beds for entrapment annually, and also whenever changes are made to the bed, such as changing the mattress or side rails. The testing is done using an entrapment testing tool which measures possible areas between the mattress and side rails or head and foot boards, where a resident could become entrapped.

During an interview with Inspector #178 on November 17, 2017, the home's Administrator indicated that it had been the ESM's understanding that he was not required to perform entrapment testing on beds which were not owned by the home. The Administrator indicated that the home will be providing the first identified resident with one of the home's beds which has been tested for entrapment hazards and passed, and entrapment testing will also be performed on the bed being used by the second identified resident.

On November 22, 2017, the Administrator provided Inspector #178 with the home's policy titled Entrapment, effective February 2016, reviewed May 2017. The Administrator indicated that as per the policy, all residents are assessed on admission for risk of entrapment, due to their physical and cognitive limitations, behaviours and/or medication regime. The Administrator further indicated that as per the policy, each bed system is to be re-evaluated for entrapment concerns annually, and any time there is a change made to the bed, such as a change in mattress. The Administrator indicated that the home's policy titled Entrapment, is based on Health Canada "A Guide to Bed Safety; Bed Rails in Hospitals, Nursing Homes and Home Health Care", and Health Canada "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and other Hazards". [s. 15. (1) (a)]

Issued on this 6th day of February, 2018

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

Original report signed by the inspector.