**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**
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## Public Copy/Copie du public

| Report Date(s) / Date(s) du Rapport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Sep 24, 2014 | 2014_285546_0028 | O-000840-14 | 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 LINDSAY NURSING HOME
240 MARY STREET WEST, LINDSAY, ON, K9V-5K5

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

SUSAN WENDT (546), CAROLINE TOMPKINS (166), 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): September 8, 9, 10, 11, 12, 15, 16, 17, 18, 2014**

**and to review the additional logs O-000323-14, O-000775-13, O-0001391-12**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Administrative Assistant, the Ward Clerk, the Environmental Manager, one Housekeeping aide, one maintenance person, the Food Services Supervisor, the Activity Director, the Resident Care Coordinator, the RAI Coordinator, the Back-up RAI Coordinator, the Pharmacist, several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW), one Health Care Aide, one Laundry Aide, one OT/PT Assistant, President of the Residents' Council, several family members and several residents.**

**During the course of the inspection, the inspector(s) completed a walk through tour of all resident areas, observed resident care, observed resident activities and restorative care, observed meal services, observed medication administration and medication storage areas, reviewed several residents’ health care records, including plans of care, medication and treatment records and PSW point of care flow sheets.  Several home policies were reviewed including policies related to the Responsive Behaviours Program, Minimizing Restraints and application of personal assistance services device(s)(PASDs), the Medication Administration and the Disposal and Destruction System, Skin and Wound Care Program, Continence Care and Bowel Management, Infection Control Program related to both, residents and staff and, the Housekeeping and Preventative Maintenance Program.  In addition, recreation calendars, Residents' Council minutes and the Administrator's monthly Family Communique newsletter were also reviewed.**

**The following Inspection Protocols were used during this inspection:**

**Accommodation Services - Housekeeping**
**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**
**Skin and Wound Care**

**Findings of Non-Compliance were found during this inspection.**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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. 3. Residents’ Bill of Rights**

**Specifically failed to comply with the following:**

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident’s individuality and respects the resident’s dignity. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that residents are treated with courtesy and respect in a way that fully recognizes the resident's individuality and dignity has been fully respected and promoted.

During this RQI inspection, an Inspector interviewed two residents; these residents indicated to the Inspector that a nurse was rude and disrespectful to them and that they had reported it to the Licensee.

This was evidenced by the Inspector's review of the Licensee's investigation and interviews with the identified residents and interviews with a registered staff. In an interview with the Inspector, a registered staff indicated that, on several occasions, another registered staff had been overheard and observed addressing a resident in a loud and disrespectful tone when in the dining room, addressing this resident's personal oral hygiene.

In addition, the Inspector's review of the Licensee's investigation and interview with a resident revealed that on several occasions the registered staff had addressed the resident in a loud tone telling the resident to move out of the way, to go sit somewhere else.

When interviewed by the Inspector, the residents did not express fear; one resident clearly indicated to the Inspector that (s)he was not afraid of this nurse. Both residents indicated to the Inspector that they did not like the nurse's tone or comments and they did not like the nurse; neither resident indicated the nurse caused any lasting emotional ramifications.

In as such, the licensee has failed to ensure that residents are treated with courtesy and respect in a way that fully recognizes the resident's individuality and dignity has been fully respected and promoted. [s. 3. (1) 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 resident in the LTCH is treated with dignity and respect in a way that promotes residents' rights and that all staff in the LTCH be made aware of the Residents' Bill of Rights., to be implemented voluntarily.***

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**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. (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).**

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**Findings/Faits saillants :**

1. The licensee failed to ensure that the written plan of care sets out clear directions to staff and others who provide direct care to the resident.

A resident's health care record was reviewed. On a specific date in April 2014, a physician ordered a stiff clip seatbelt as a restraint while in seat of wheelchair and side rails while in bed. Consent was obtained from the resident's substitute decision maker on a specific date in April 2014.

According to the written plan of care in effect at the time of the inspection, the resident used a PASD to assist with positioning in wheelchair. Interventions were listed as uses 1 bedrail in bed on the left side and uses seatbelt with alarm applied when in wheelchair and removed when in bed.

A registered staff was interviewed and showed the Inspector that routine monitoring and documentation in Point of Care (POC) included one bedrail on the left side. There was no task or prompt to indicate that the resident wore a seatbelt.

A registered staff was interviewed and indicated that the following safety intervention was listed in POC: bed alarm. A registered staff confirmed that this did not inform staff that a specific resident wore a seatbelt. A registered staff reviewed the resident's chart and noted that according to the eMARS, on a specific date in August 2014, the order for a stiff clip seatbelt as restraint while in seat of wheelchair had been discontinued by a registered staff member. [s. 6. (1) (c)]

2. The licensee failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

A resident's health care record was reviewed. According to the quarterly Medication Review (Chart) Report (orders signed by the prescribing physician on a specific date in August 2014), a resident was ordered a hard clip seatbelt with tray while in wheelchair, to be monitored each shift. The resident's written plan of care stated to use the seatbelt and to apply and remove as per policy and procedure.

Throughout the course of the inspection, the resident was observed to consistently wear a front closure lapbelt. A tray was not observed.

A staff was interviewed and showed the Inspector that the resident was monitored hourly in Point of Care (POC) for a seatbelt restraint. There was no indication that the resident used a wheelchair tray or that it was monitored each shift as ordered by the physician.

The licensee failed to ensure that the care set out in the plan of care was provided to the specified resident as it related to the physician's order for a wheelchair tray. [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 residents' plans of care are based on resident care needs and that written plans of care set out clear directions to staff and others who provide direct care to the resident(s), to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices**

**Specifically failed to comply with the following:**

**s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:**
**1. There is a significant risk that the resident or another person would suffer serious bodily harm if the resident were not restrained. 2007, c. 8, s. 31 (2).**
**2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).**
**3. The method of restraining is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable methods that would be effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).**
**4. A physician, registered nurse in the extended class or other person provided for in the regulations has ordered or approved the restraining. 2007, c. 8, s. 31 (2).**
**5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).**
**6. The plan of care provides for everything required under subsection (3). 2007, c. 8, s. 31 (2).**

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**Findings/Faits saillants :**

1. The licensee failed to ensure a physician or registered nurse in the extended class has ordered the restraining and that the restraining of the resident has been consented to by the resident or a substitute decision maker.

Throughout the course of the inspection, a specific resident was consistently observed to wear a front closure lapbelt when in wheelchair.  On a specific date in September 2014, the resident was asked by the Inspector if (s)he could release the belt, and it was observed that (s)he could not.

A review of the resident's health care record indicated that the resident was at moderate risk for falls and required extensive assistance for transfers.  The written plan of care did not include the use of a lapbelt.  Point of Care (POC) was reviewed, and monitoring of the resident's lapbelt was not included in the documentation.

During an interview with the Inspector, two staff stated that the resident wore a lapbelt when in wheelchair.  During a conversation with the Inspector, the DOC indicated that all residents wearing lapbelts had been assessed as requiring them.

The specific resident did not have an order for a lapbelt restraint from a physician or registered nurse in the extended class, and there was no signed consent for the lapbelt restraint. [s. 31. (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 residents with restraints have an order from a physician or registered nurse in the extended class, in addition to having a signed consent by the resident's substitute decision-maker, to be implemented voluntarily.***

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**WN #4:  The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 59. Family Council**

**Specifically failed to comply with the following:**

**s. 59. (7) If there is no Family Council, the licensee shall,**
**(a) on an ongoing basis advise residents’ families and persons of importance to residents of the right to establish a Family Council; and 2007, c. 8, s. 59. (7).**
**(b) convene semi-annual meetings to advise such persons of the right to establish a Family Council. 2007, c. 8, s. 59. (7).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that semi-annual meetings are convened to advise residents' families and persons of importance to residents of the right to establish a Family Council.

In the monthly Caressant Care Family Communiques(June 2014 issue and September 2014 issue, as no newsletter was sent in August 2014), it was indicated that "Families working together to provide support, share experiences, and seek solutions to common problems. You can make a difference. Help us form a Family Council. Please see Joanne in the Activity Department for more information.”

During an interview with an Inspector on a specific date in September 2014, the Administrator confirmed that the home had only sent out the aforementioned newsletters, as a notice to recruit Family Members for the reestablishment of a Family Council at the Home and as such, the licensee had not convened semi-annual meetings during the past year to advise or recruit residents’ families and persons of importance to residents of the right to establish a Family Council. [s. 59. (7) (b)]

**Issued on this 24th day of September, 2014**

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