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

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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
Jan 25, 2017	2016_327570_0027	013436-16	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 LINDSAY NURSING HOME
240 MARY STREET WEST LINDSAY ON K9V 5K5

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

SAMI JAROUR (570), LYNDA BROWN (111)

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): December 12-16 and 19, 20, 2016

Resident Quality Inspection (RQI) Intake #013436-16. There were four additional intakes assigned to the RQI and such were inspected concurrently with this inspection;
Summary of Intakes:
1) 028583-16 – Complaint, related to specific continence care product not being offered to a resident;
2) 029316-16 – Complaint, specific to Nursing services; no RN available at the home;
3) 033381-16 – Follow Up to compliance order #001 issued under inspection #2016_328571_0023, specific to LTCHA, 2007, s. 6. (4), with compliance date of November 21, 2016;
4) 034037-16 – Follow Up to compliance order #002 issued under inspection #2016_328571_0023, specific to LTCHA, 2007, s. 6. (10), with compliance date of November 21, 2016.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care (DOC), Resident Care Coordinator (RCC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Environmental Services Manager (ESM), Physiotherapist, Housekeeping Staff, RAI-MDS coordinator, Activity Manager, Residents' Council President, Family Council President, Residents and Families.

Also during the course of this inspection, the inspector(s), toured the home, observed medication administration, staff to resident interactions, and resident to resident interactions,
reviewed clinical health records, staff schedules, minutes of both the Family and Resident Councils, and reviewed the licensee's policies related to restraints, continence program and infection prevention and control.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council
Skin and Wound Care
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #002	2016_328571_0023	111
LTCHA, 2007 S.O. 2007, c.8 s. 6. (4)	CO #001	2016_328571_0023	111

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. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD 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. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #016's plan of care include alternatives to the use of PASD device were considered, and tried, but have not been effective to assist the resident with the routine activity of living.

Review of clinical records for resident #016 by Inspector #570 indicated the resident was admitted to the home on a specified date with multiple diagnosis including dementia. The record review indicated a physician order on on a specified date as follows: PASD device; Apply PASD device when in wheelchair and tilt wheelchair for comfort.

On December 13, 2016, resident #016 was observed by inspector #111 sitting in wheelchair with PASD device applied. The wheelchair was not tilted at the time of the

observation.

On December 16, 2016, resident #016 was observed by Inspector #570 sitting in wheelchair (tilt was not engaged); PASD device was in use and properly applied. The resident was unable to undue the PASD device when asked by the inspector.

On December 16, 2016 interview with RPN #110, indicated to Inspector #570 that resident #016 is using a tilt wheelchair; the resident does not have a restraint but has a PASD device and the resident could undue it. RPN #110 asked resident #016, who was in the dining room sitting in wheelchair with PASD device applied, to undue/take off the device, the resident was unable to undue the device when asked by RPN #110 with inspector present.

Review of the current plan of care related to the use of the PASD device for resident #016 indicated that resident uses PASD to aide in positioning when in wheelchair. The plan of care under interventions directs: uses PASD device; apply when in wheelchair and remove when out of wheelchair.

Review of clinical records, both paper and electronic records, for resident #016 indicated no documented evidence that alternatives to the use of the PASD device were considered, and tried, but have not been effective to assist the resident with the routine activity of living prior to using the seatbelt. [s. 33. (4) 1.]

2. The licensee has failed to ensure that resident #010's plan of care include alternatives to the use of a PASD device were considered, and tried, but have not been effective to assist the resident with the routine activity of living.

Review of clinical records for resident #010 by Inspector #570 indicated the resident was admitted to the home on a specified date with multiple diagnosis including cognitive decline. The record review indicated a physician order on a specified date as follows: PASD device while in wheelchair.

On December 13 and 15, 2016, resident #010 was observed by Inspector #570 sitting in wheelchair with a PASD device applied. The resident was unable to undue the device when asked by inspector on both observations.

On December 16, 2016 at 1135 hours, interview PSW #111 indicated to Inspector #570 that resident #010 has a restraint device and the resident cannot undue the device; PSW

#111 further indicated that the resident was monitored and the device application and the monitoring was documented on the Point of Care (POC).

On December 16, 2016 at 1448 hours, interview RPN #109 indicated to Inspector #570 that resident #010 has a PASD device to keep the resident safe in the wheelchair.

Review of the current plan of care related to the use of PASD device for resident #010 indicated that resident uses PASD to assist with positioning in wheelchair. The plan of care under interventions directs: uses PASD device; apply when in wheelchair and remove when out of wheelchair.

Review of clinical records, both paper and electronic records, for resident #010 indicated no documented evidence that alternatives to the use of PASD device were considered and tried prior to using the specified device. RPN #109 was unable to provide any documentation that alternatives to the use of PASD were considered, and tried, but have not been effective to assist the resident with the routine activity of living prior to using the specified device.

On December 20, 2016 interview with the Resident Care Coordinator (RCC) who oversees the restraints and falls committee indicated to the inspector that no alternatives were tried prior to the use of the specified device for resident #010 and that the use should have been completed and documented on the Safety Plan Interventions form which was not completed for resident #010. [s. 33. (4) 1.]

3. The licensee has failed to ensure that resident #005's plan of care include alternatives to the use of a specified device as a PASD were considered and tried, but have not been effective to assist the resident with the routine activity of living.

Review of clinical records for resident #005 by Inspector #570 indicated the resident was admitted to the home on a specified date with multiple diagnosis including cognitive decline. The record review indicated a physician order on a specified date as follows: PASD device while in wheelchair to aid with maintaining an upright position while in wheelchair.

On December 14 and 15, 2016, resident #005 was observed by Inspector #570 sitting in wheelchair with a specified device applied. The resident was unable to undue the specified device when asked by inspector on both observations.

On December 16, 2016 at 1107 hours, interview PSW #111 indicated to Inspector #570 that the specified device used by resident #005 is considered a restraint as the resident cannot undue the device; the resident was monitored for safety and proper application of the specified device and the monitoring was documented on the Point of Care (POC).

On December 16, 2016 at 1428 hours, interview RPN #109 indicated to Inspector #570 that resident #005 has a specified device used as PASD for positioning in the wheelchair; resident was unable to undue the specified device when asked by the RPN with inspector present. RPN #109 indicated that he/she was not aware that the resident cannot undue the specified device.

Review of the current plan of care related to the use of a specified device for resident #005 indicated that resident will successfully utilize the PASD to assist with mobility. The plan of care under interventions directs: uses specified device when in wheelchair; apply when in wheelchair.

Review of clinical records, both paper and electronic records, for resident #005 indicated no documented evidence that alternatives to the use of specified device as a PASD were considered and tried, but have not been effective to assist the resident with the routine activity of living prior to using the specified device.

On December 20, 2016 interview with the Resident Care Coordinator (RCC) who oversees the restraints and falls committee indicated to the inspector that no alternatives were tried prior to the use of the specified device for resident #005 and that the use of restraints/PASDs should have been documented on the Safety Plan Interventions form which was not completed for resident #005. [s. 33. (4) 1.]

4. The licensee has failed to ensure that the use of specified device as a PASD for resident #010 has been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

Review of clinical records both paper and electronic records for resident #010 indicated no documented evidence that consent was obtained by the SDM of the resident regarding the use of a specified device as a PASD.

On December 16, 2016 at 1448 hours, interview RPN #109 indicated to Inspector #570 that resident #010 has a specified device to keep the resident safe in the wheelchair. RPN #109 was unable to provide any documentation that consent was obtained prior to

using the specified device for resident #010.

On December 20, 2016 interview with the RCC indicated to the inspector that he/she could not find any documentation that a consent was obtained from the SDM prior to using the specified device for resident #010. [s. 33. (4) 4.]

5. The licensee has failed to ensure that the use of a specified device as a PASD for resident #005 has been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give that consent.

Review of clinical records both paper and electronic records for resident #005 indicated no documented evidence that a consent was obtained by the SDM of the resident regarding the use of a specified device as a PASD.

On December 16, 2016 at 1428 hours, interview RPN #109 indicated to Inspector #570 that resident #010 has a specified device used as a PASD for positioning in the wheelchair; the resident was unable to undue the specified device when asked by the RPN with inspector present. RPN #109 indicated that he/she was not aware that the resident cannot undue the specified device and was unable to provide documentation that consent was obtained prior to using the specified device as a PASD for resident #005.

On December 20, 2016 interview with the RCC indicated to the inspector that he/she could not find any documentation that a consent was obtained from the SDM prior to using the specified device for resident #005. [s. 33. (4) 4.]

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 by ensuring alternatives to using a PASD for any resident are tried and consent is obtained by the SDM of the resident prior to using the PASD, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee had failed to ensure that all staff participate in the implementation of the infection prevention and control program.

During this inspection (from December 12-16 and 19-20, 2016), the home was in enteric outbreak throughout the home and affecting approximately 56 residents.

On December 15, 2016 between 10:00 to 11:00 hours, observation by Inspectors #111 & # 672 noted all housekeeping staff (HSK #106, #107 & #108) were wearing the same pair of gloves while cleaning more than one resident room and not performing hand hygiene in between cleaning of resident rooms. Two housekeeping staff (#106 & #107) were also observed wearing the same pair of gloves after cleaning in common areas and/or while walking throughout the home (entering the elevator/delivering newspaper to nursing station) and not remove the gloves or perform hand hygeine. One housekeeper (#107) was observed wearing the same mask during this time throughout the home.

On December 15, 2016 at approximately 11:30 hours, interview with HSK #106 & #107 by Inspectors #111 & # 672 when asked why they were wearing gloves throughout the home both stated "to protect themselves from the outbreak". Interview with HSK #107 at that time was asked why they were wearing a mask and stated "to also protect herself from the outbreak".

On December 15, 2016, interview with the RCC (Infection Prevention and Control Lead-IPC) indicated the expectation is that all staff participate in hand hygiene practices as per best practices, which includes donning gloves, gown and mask upon entering any resident rooms on isolation precautions and then removing the PPE's and performing hand hygiene prior to leaving the room. The IPC lead indicated that also included housekeeping staff. The IPC lead indicated awareness that housekeeping staff were not participating in hand hygiene practices as per best practices but no other actions were taken. [s. 229. (4)]

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 by ensuring that all staff including housekeeping staff participate in the implementation of the infection prevention and control program specifically using PPEs and performing hand hygiene, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #025 was provided with a range of continence care products based on the resident's individual assessed need.

Related to Complaint Log #028583-16:

On December 19, 2016, during a telephone interview, a family member of resident #025 expressed concerns that the resident was not offered a choice of a pull-up to manage the resident's incontinence needs. The family member indicated to the inspector that the resident was not able to wear the alternative product "diaper" provided by the home. The resident continued to purchase and use own pull-ups until about 2 months ago when the resident had to use what the home offered due to cost. The home did not offer any kind of pull-ups to the resident.

On December 20, 2016 at 1140 hours, interview with resident #025 indicated to Inspector #570 that they had used pull-ups with pads that they bought but the pull-ups got so expensive and thus had to use a different incontinence product offered by the home in

the form of a mesh pants with a pad. The resident further indicated that the home had never offered any pull-ups.

Review of clinical records for resident #025 indicated the resident was admitted to the home on a specified date. The records review indicated continence assessment completed for resident #025 on October 3, 2015, January 2, 2016, March 24, 2016, June 20, 2016, July 6, 2016 and September 13, 2016 indicated under product used for containment: own pull-ups ; the continence assessment completed on September 23, 2016 indicated the resident was using blue liner at all three shifts.

Review of progress notes for resident #025 indicated on July 6, 2016 the resident requested to use her own pull-ups that her family supplied during the day and to use a day plus liner during the evening and night hours; there was no documented evidence in the progress notes that the home offered the resident a choice of pull-ups.

Review of the Tena Incontinence Management System (new admission and product change form) completed for resident #025 on July 8, 2016 indicated the resident has requested to use a yellow liner at bed time and during the night; she wanted to use her own pull-up during the day.

Review of progress notes for resident #025 indicated on September 23, 2016, during the annual Family/Team Conference, the family was concerned about the cost of the pull-ups provided by the family and they wanted to use the home’s products as a trial if the resident likes them.

Review of the Tena Daily Distribution List dated December 20, 2016 indicated that range of incontinence products available at the home as: small white pad (WP), small to medium (blue pad (BP), medium to large yellow pad (YP), special pad used by one resident (white with yellow stripes (CP), briefs: medium (MB), large (LB), and extra-large (BEIGE). The distribution list did not include any choice of pull-ups to be used or offered to residents.

On December 20, 2016 at 1009 hours, during an interview, the Resident Care Coordinator (RCC) indicated to the inspector that he/she manages the incontinence program in the home and responsible in ordering incontinence products. The RCC indicated the Tena incontinence management system used at the home included a list of the products available at the home and offered to residents in various shifts; the RCC confirmed to the inspector that the list did not include any pull-ups for any of the three

shifts. The RCC further indicated that all residents in the home get assessed for the products and based on the assessment residents are offered whatever products available from Tena including stretch pants and mesh pants but no pull-ups are offered.

On December 20, 2016, during a follow up interview, the RCC indicated to the inspector that the home does not offer pull-ups to residents who were assessed for pull-ups and those residents supply their own pull-ups; The RCC indicated that the home did not have a supply of pull-ups available at hand except those supplied and paid for by families.

Therefore the licensee did not offer resident #025 a range of incontinence products that include a pull-up specifically when the resident's continence assessments indicated use of a pull-up for containment. Resident #025 continued to supply their own pull-ups until using a different type of incontinence product supplied by the home due to the incurred cost of pull-ups. [s. 51. (2) (f)]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 219. Retraining

Specifically failed to comply with the following:

s. 219. (4) The licensee shall ensure that the training and retraining for staff in infection prevention and control required under paragraph 9 of subsection 76 (2) and subsection 76 (4) of the Act includes,
(a) hand hygiene; O. Reg. 79/10, s. 219 (4).
(b) modes of infection transmission; O. Reg. 79/10, s. 219 (4).
(c) cleaning and disinfection practices; and O. Reg. 79/10, s. 219 (4).
(d) use of personal protective equipment. O. Reg. 79/10, s. 219 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff received annual re-training on infection control practices, specifically hand hygiene practices.

Observation of housekeeping staff during the morning of December 15, 2016 indicated HSK #106, #107 & #108 were all noted to be wearing the same gloves while cleaning more than one resident room and while cleaning common areas. There was also no hand hygiene completed in between resident rooms.

During the morning of December 19, 2016, HSK #113 & #114 were observed by Inspectors #111 & # 672 to be wearing gloves while cleaning all common areas.

On December 15, 2016, interview with IPC Lead by Inspector #111 during this inspection (and while the home was in enteric outbreak) indicated that he/she only provides annual retraining to nursing staff on infection, prevention and control practices, specifically hand hygiene and the use of personal protective equipment (PPE's). The IPC Lead indicated that the Environmental Services Manager (ESM) is responsible for annual re-training all housekeeping staff on infection control practices.

Interview with the ESM by Inspector #111 during this inspection, indicated he/she had not provided annual training to all housekeeping staff this year but all the housekeepers are aware of proper infection control practices. The ESM was not aware that housekeepers were not removing their gloves in between cleaning of resident rooms and while cleaning common areas or washing their hands in between resident rooms. [s. 219. (4) (a)]

Issued on this 27th day of January, 2017

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

Original report signed by the inspector.