Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 28, 2020	2020_643111_0018	019327-20	Complaint

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

LYNDA BROWN (111)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): October 7 to 9 and 12 to 16, 2020.

A complaint inspection related to continence care, oral care, laundry and communication system.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), Registered Nurse (RN), Personal Support Worker (PSW), the resident and the resident's Substitute Decision Maker (SDM).

During the course of the inspection, the inspector: observed the resident, observed the resident's room, reviewed the resident's health record, the incontinence product lists, the incontinence management system forms and observed the incontinence supply storage.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Continence Care and Bowel Management
Falls Prevention
Personal Support Services

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 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	Légende 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. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the resident had their personal items, such as dentures and toothbrushes, labelled within 48 hours of admission and in the case of acquiring new items.

A shared resident bathroom was observed with an unlabelled denture cup with an unlabelled denture soaking in water and a number of toothbrushes that were not labelled. Resident #001's care plan indicated the denture had belonged to them and the resident confirmed they were supposed to be wearing the denture, but did not have them in. A PSW confirmed they provided care to the resident and thought the denture belonged to the resident's roommate. The PSW confirmed that not only was the denture and denture cup unlabelled, but the toothbrushes and should have been labelled to identify which resident they belong to. By not labelling personal items in a shared bathroom, including dentures and toothbrushes, could lead to possible cross contamination.

Sources: resident #001's care plan, observation of resident #001, observation of resident #001's bathroom and interviews with resident #001 and staff.

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 each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and of acquiring, in the case of new items, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

The licensee has failed to ensure that a resident received oral care to maintain the integrity of the oral tissue, cleaning of dentures, and including mouth care in the morning and evening.

A resident's care plan related to oral care, included staff to provide oral care to the resident twice daily (morning and bedtime), had some of their own teeth and included a denture. The denture was to be cleaned, put in place each morning and then removed and soaked overnight. The resident's SDM indicated the resident was to have their denture put in place each morning with an adhesive and offered mouthwash. Observation of the resident's shared bathroom identified an unlabelled denture soaking in water in an unlabelled denture cup, along with an unused bottle of mouthwash. The resident was also observed after lunch, with no denture in place and the resident confirmed they were supposed to be wearing their denture which would assist with eating. A PSW confirmed they provided care to the resident that morning, was not aware that the resident had a denture or was to be offered mouthwash. The PSW thought the denture belonged to the resident's roommate.

Sources: resident care plan and kardex, observation of shared bathroom and a resident, and interviews of a resident, their SDM and staff.

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,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

The licensee has failed to ensure that a resident who was incontinent, had an individualized plan of care to promote and manage bowel and bladder incontinence and was based on an assessment.

A resident was observed on various dates and time, wearing different types of pads, inside their underwear. There was no mesh underwear used to keep the pad securely in place and prevent leaking. Review of the resident's recent continence assessment indicated the resident was to be wearing a large pad. The resident's care plan and continence list indicated the resident was to be wearing a medium pad. The RN responsible for ordering the incontinence products indicated they ordered the products and created the continence list based on the nursing staff completing the appropriate incontinence management form. The RN indicated the resident was to be wearing a medium pad as per the continence list. The RN confirmed the incontinence management form completed for the resident indicated the resident was to be using a large brief (not a pad) and the form should have been updated. The DOC indicated the resident was correctly assessed for a medium pad, should have been provided the mesh underwear to keep the pad securely in place and should have had the continence assessment updated.

Sources: a resident's care plan, incontinence management system form, continence assessment, continence product list, observations of the resident and interviews with the resident's SDM and staff.

Issued on this 29th day of October, 2020

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

Original report signed by the inspector.