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 prévue le Loi de 2007 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 sions de longue durée

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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
May 13, 2016;	2015_418615_0035 (A1)	032444-15	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 LISTOWEL NURSING HOME
710 RESERVE AVENUE SOUTH LISTOWEL ON N4W 2L1

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

HELENE DESABRAIS (615) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The home requested to extend the date for compliance to March 31, 2016, to be able to comply with the orders.

Issued on this 13 day of May 2016 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

HELENE DESABRAIS (615) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): December 1, 2, 3, 4, 7, 8 and 9, 2015.

Concurrent inspection: Critical Incident Log#030558-15, related to prevention of falls.

The Inspector(s) also toured all resident home areas and common areas, observed residents and the care provided to them, resident-staff interactions, recreational activities, dining service, medication administration, medication storage areas, laundry room, posting of required information, general maintenance, cleanliness and condition of the home. Health care records and plans of care for identified residents were reviewed, staffing schedules and relevant policies and procedures.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing, Nutritional Manager, Resident Assessment Instrument (RAI) Coordinator, forty Residents, three family members, a Maintenance staff member, two Registered Nurses (RN), a Registered Practical Nurse and six Personal Support Workers.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Continence Care and Bowel Management

Dining Observation

Falls Prevention

Family Council

Hospitalization and Change in Condition

Infection Prevention and Control

Medication

Personal Support Services

Residents' Council

Responsive Behaviours

Skin and Wound Care

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

- **7 WN(s)**
- **4 VPC(s)**
- **2 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. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of maintenance services, that there were schedules in place for routine, preventative and remedial maintenance.

Observations made throughout the Resident Quality Inspection (RQI), revealed the following identified deficiencies in maintenance:

Doors, door frames and wall surfaces observed to have paint scrapes and/or damages, stained and damaged ceiling tiles, ceiling lights with dead insects and/or burnt out, loose or missing pieces of baseboards, a metal box with electrical wires sticking out of the wall, holes in the wall, heat registers with paint scrapes and/or pulled away from the wall,ceiling vents with dust, residents bathrooms noted to have base of toilet with rust/corrosion, toilet caps missing, toilet bolts rusted, towel bars loose, and cabinet doors and base damaged.

In an interview with the Administrator and the maintenance staff, they both acknowledge that every room had not been inspected quarterly, and acknowledged the deficiencies throughout the home.

The Administrator and the maintenance staff acknowledged that the Preventative Maintenance program of the home was not fully implemented and confirmed the home's expectation was that there should be schedules in place for routine, preventative and remedial maintenance and that the preventative maintenance program should be implemented. [s. 90. (1) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care

Findings/Faits saillants :

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

A review of the plan of care in the clinical record of a Resident revealed that the resident required specific care interventions.

In an interview with two Personal Support Workers, it was confirmed that the Resident did not require the care interventions as directed in the care plan. They confirmed that the plan of care was not accurate and did not give clear directions.

The Director of Nursing confirmed the home's expectation was that the plan of care should set out clear directions to staff and others who provided care to the resident.[s. 6. (1) (c)] (515)

2.The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

Observations of a Resident throughout the RQI revealed the resident had poor oral hygiene.

A review of the care plan revealed that interventions for hygiene and grooming including mouth care were documented as "Extensive. Provide weight bearing support 3 or more times per week, OR complete staff performance of task, most days but not every day."

The Director of Nursing acknowledged that the intervention did not address the needs of the resident.

The Director of Nursing, confirmed the home's expectation was that the care set out in the plan of care should be based on an assessment of the resident and the needs and preferences of that resident.[s. 6. (2)] (515)

3.The licensee has failed to ensure that the care set out in the plan of care was based

on an assessment of the resident and the needs and preferences of that resident.

A review of the plan of care in the clinical record of a Resident indicated no documented interventions for hygiene, grooming including mouth care and transfer methods of the resident.

In an interview with two Personal Support Workers, they identified the transfer method of the resident however, confirmed that this was not documented along with interventions for hygiene and grooming including mouth care.

In an interview with the Director of Nursing, confirmed that the transfer method of the resident and interventions for hygiene and grooming including mouth care were not documented in the plan of care for the resident.

The Director of Nursing, confirmed the home's expectation was that the care set out in the plan of care should be based on an assessment of the resident and the needs and preferences of that resident.[s. 6. (2)] (615)

4.The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

During staff interviews and a clinical record review, it was revealed that a Resident exhibited responsive behaviours.
The Resident was being followed by the Behavioural Support Ontario (BSO) team and Seniors Mental Health for ongoing responsive behaviours.

A review of the plan of care revealed there was no evidence that these responsive behaviours and interventions to manage the behaviours were documented.

During interviews, with the BSO representative and the RAI Coordinator, it was confirmed these behaviours and interventions to manage the identified behaviours were not documented in the plan of care, and acknowledged that the care set out in the plan of care should be based on an assessment of the resident and the needs and preferences of that resident.[s. 6. (2)] (137)

5.The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs change or care set out in

the plan was no longer necessary.

A review of the plan of care in the clinical record of a Resident revealed a specific intervention for the prevention of falls. When asked, the resident indicated that she/he did not use the specific intervention identified in the plan of care.

In an interview with two Personal Support Workers and a registered staff, they acknowledged that the resident refused to use the specific intervention. They confirmed that the care set out in the Resident's plan of care was no longer necessary.

The Director of Nursing confirmed the home’s expectation was that the resident should be reassessed and the plan of care reviewed and revised when care needs change.[s. 6. (10) (b)] (515)

6.The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs change or care set out in the plan was no longer necessary.

A review of the plan of care in the clinical record of a Resident indicated specific directions for staff to clean the resident's teeth.

In an interview and observation with the Resident, it was confirmed the resident did not have any teeth and had not had teeth for over a year.

In an interview with two Personal Support Workers, it was confirmed that the Resident did not have teeth, that the dentures broke over a year ago, and a review of the progress notes indicated the dentures broke on a specific date.

In an interview with the RAI Coordinator, it was revealed she was not aware that the resident did not have teeth and it was confirmed that the plan of care was not reviewed and revised when care needs changed.[s. 6. (10) (b)] (137) [s. 6.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)The following order(s) have been amended:CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) 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,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

A review of the policy "Assessment of Residents", date reviewed, May 2015 stated "16. In addition to the MDS assessment, quarterly and upon return from hospital, a Caressant Care continence assessment shall be completed if the resident scores 2 or higher in section H of MDS assessment."

A review of the Minimum Data Set (MDS) assessments, section H, for a Resident, revealed that 6/8 (75 per cent) of the scores were greater than 2.

A clinical record review, for the Resident, revealed there was no documented evidence that Caressant Care continence assessments were completed as per the home's policy.

The RAI Coordinator and Director of Nursing confirmed the continence assessments

had not been completed and acknowledged that the home's policy had not been complied with. [s. 8. (1) (b)]

2. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

On a specific date, the medication fridge was observed to have sticky dried fluids on every shelf, the door and the bottom of the fridge. The observation was confirmed by a Registered Nurse.

A review of the home's schedule of duties entitled "Safety Schedule and Night Duties", dated December 7, 2015, revealed the schedule directed staff to "clean and defrost the Med Room fridge and lab fridges weekly on Mondays". A check mark, indicating this task was done and initialled by the night nurse was observed.

The Director of Nursing acknowledged that the fridge was unclean and the home's expectation was that furnishings and equipment were to be kept clean and sanitary as per the home's schedule duties. [s. 8. (1) (b)]

3. The licensee failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with.

During stage one of the Resident Quality Inspection (RQI), 40 residents' clinical records were reviewed and revealed that 25/40 (62.5 per cent) residents' heights had not been taken yearly and 12/40 (30 per cent) residents' weights had not been taken monthly.

Review of the home's policy "Monthly Weights", effective January, 2012 and reviewed November, 2015 stated "Resident's weights are to be taken monthly and recorded as an indicator that the residents' nutritional needs are being met and to determine any changes to Nutritional Risk Level and/or to implement necessary Nutrition Interventions due to weight loss and/or weight gain."

Review of the home's policy "Heights", effective February,2013 and reviewed May, 2015 stated "Each resident's height shall be measured and recorded upon admission and annually thereafter."

Interview with the RAI Coordinator acknowledge that some residents' heights and weights have not been done and recorded.

Interview with the Administrator and Director of Nursing confirmed the home's expectation was to measure and record weight monthly and height annually and acknowledged that the home's policy had not been complied with. [s. 8. (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 any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that housekeeping procedures were implemented to ensure the home, furnishings and equipment were kept clean and sanitary.

Observations made throughout the Resident Quality Inspection (RQI), revealed the following identified deficiencies in housekeeping:

Bathroom doors with metal sheet soiled with brown streaks, lower wall by the nursing station soiled with dry fluids,thick buildup of grime on floor by heat register, baseboards, door and wall by sink in the lounge soiled with food debris and dry fluids,food serving counter wall soiled with food debris and dry fluids, floors soiled at edges of baseboards, doors with metal sheet soiled with brown streaks, bathrooms baseboards soiled, base of toilets with black residues, grab rail soiled, cobwebs.

A review of the home's policy and procedure entitled "Cleaning Guidelines - Resident Rooms", effective February 2013, stated the residents' room including washroom shall be thoroughly cleaned and monitored for safety hazards daily and, thorough cleaning consists of clean walls, windows and baseboards.

The Administrator, over seeing housekeeping, confirmed the home's expectation was that housekeeping policies should be complied with.

During a tour with the Administrator, over seeing housekeeping, and Director of Nursing, the identified deficiencies were confirmed, as well as the home's expectations was that the home was to be kept clean and sanitary. [s. 87. (2) (a)]

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 procedures are implemented for cleaning the home, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances at the home were kept inaccessible to residents at all times.

On a specific date, during the initial tour of the home, the doors to the Housekeeping Room and the Tub Room on the East Wing home area were observed to be ajar. Hazardous substances such as tub disinfectant, insect and ant killer, bleach, stainless steel polish, mild acid bowl cleaner, furniture polish and Oxivir Plus were observed in the rooms. A Housekeeper and a Personal Support Worker confirmed the observations and acknowledged that the substances were accessible to residents and that this posed a potential risk to residents.

In an interview, the Administrator confirmed the home's expectation was that all hazardous substances were to be kept inaccessible at all times. [s. 91.]

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 hazardous substances at the home are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #6: 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 were stored in an area or a medication cart that was kept secure and locked.

On a specific date, a medication cart in the East hallway outside Room 5, was observed unlocked, unattended and the Registered Practical Nurse was providing care to a resident in a room behind a curtain. Three residents were present in the hallway.

The Registered Practical Nurse acknowledged that the cart was being used, that it was left unlocked, and unattended, and that this posed a potential risk to residents.

In an interview, the Administrator confirmed the expectation that drugs were to be stored in an area or medication cart that was kept secure and locked. [s. 129. (1) (a) (ii)]

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 that drugs are stored in an area or a medication cart that is kept secure and locked,, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 16. Every licensee of a long-term care home shall ensure that every window in the home that opens to the outdoors and is accessible to residents has a screen and cannot be opened more than 15 centimetres. O. Reg. 79/10, s. 16; O. Reg. 363/11, s. 3.

Findings/Faits saillants :

1. The licensee has failed to ensure that every window in the home that opened to the outdoors and was accessible to residents had a screen and could not be opened more than 15 centimetres.

On a specific date, during the initial tour of the home, one of two windows (50 per cent) in the TV lounge at the main entrance of the home was observed to have a broken latch, did not have a screen in place and was able to be opened 30 centimetres to the outside. The observation was confirmed by the Director of Nursing.

In an interview, the Director of Nursing, confirmed the home's expectation that a window that opened to the outdoors, and was accessible to residents, should have a screen and not open more than 15 centimetres. [s. 16.]

Issued on this 13 day of May 2016 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : HELENE DESABRAIS (615) - (A1)

Inspection No. / No de l'inspection : 2015_418615_0035 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 032444-15 (A1)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : May 13, 2016;(A1)

Licensee / Titulaire de permis : CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE, WOODSTOCK, ON, N4S-3V9

LTC Home / Foyer de SLD : CARESSANT CARE LISTOWEL NURSING HOME
710 RESERVE AVENUE SOUTH, LISTOWEL, ON, N4W-2L1

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Name of Administrator / Nom de l'administratrice ou de l'administrateur : LENORA BELLE

To CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,

(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and

(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Order / Ordre :

(A1)
The licensee must take action to achieve compliance by:

a) Implementing their Preventive Maintenance program to ensure schedules are in place for routine, preventative and remedial maintenance;
b) Ensuring that maintenance inspections are completed and documented in accordance with the home s policy and;
c) Ensuring an action plan based on the identified deficiencies is documented, monitored and evaluated for completion.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Grounds / Motifs :

1. The licensee has failed to ensure that as part of the organized program of maintenance services, that there were schedules in place for routine, preventative and remedial maintenance.

Observations made throughout the Resident Quality Inspection (RQI), revealed the following identified deficiencies in maintenance:

Doors, door frames and wall surfaces observed to have paint scrapes and/or damages, stained and damaged ceiling tiles, ceiling lights with dead insects and/or burnt out, loose or missing pieces of baseboards, a metal box with electrical wires sticking out of the wall, holes in the wall, heat registers with paint scrapes and/or pulled away from the wall,ceiling vents with dust, residents bathrooms noted to have base of toilet with rust/corrosion, toilet caps missing, toilet bolts rusted, towel bars loose, and cabinet doors and base damaged.

In an interview with the Administrator and the maintenance staff, they both acknowledge that every room had not been inspected quarterly, and acknowledged the deficiencies throughout the home.

The Administrator and the maintenance staff acknowledged that the Preventative Maintenance program of the home was not fully implemented and confirmed the home's expectation was that there should be schedules in place for routine, preventative and remedial maintenance and that the preventative maintenance program should be implemented. (615)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Mar 31, 2016(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 6. Plan of care

Order / Ordre :

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;
(b)the goals the care is intended to achieve; and
(c)clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).
s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).
s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a)a goal in the plan is met;
(b)the resident's care needs change or care set out in the plan is no longer necessary; or
(c)care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

The licensee must take action to achieve compliance by:

a) Ensuring that each resident has a written plan of care that sets out clear directions to staff and others who provide direct care to residents.
b) Ensuring that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.
c) Ensuring that the resident is reassessed and the plan of care reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary.
d) The plans of care for residents #001, #002 and #003 are reassessed and revised to reflect their current needs.
e) The home shall implement a procedure to ensure ongoing compliance and monitoring of the plans of care for all residents.

Grounds / Motifs :

1. A review of the plan of care in the clinical record of a Resident revealed that the resident required specific care interventions.

In an interview with two Personal Support Workers, it was confirmed that the

Resident did not require the care interventions as directed in the care plan. They confirmed that the plan of care was not accurate and did not give clear directions.

The Director of Nursing confirmed the home's expectation was that the plan of care should set out clear directions to staff and others who provided care to the resident. [s. 6. (1) (c)] (515)

2.The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

Observations of a Resident throughout the RQI revealed the resident had poor oral hygiene.

A review of the care plan revealed that interventions for hygiene and grooming including mouth care were documented as "Extensive. Provide weight bearing support 3 or more times per week, OR complete staff performance of task, most days but not every day."

The Director of Nursing acknowledged that the intervention did not address the needs of the resident.

The Director of Nursing, confirmed the home's expectation was that the care set out in the plan of care should be based on an assessment of the resident and the needs and preferences of that resident.[s. 6. (2)] (515)

3.The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

A review of the plan of care in the clinical record of a Resident indicated no documented interventions for hygiene, grooming including mouth care and transfer methods of the resident.

In an interview with two Personal Support Workers, they identified the transfer method of the resident however, confirmed that this was not documented along with

interventions for hygiene and grooming including mouth care.

In an interview with the Director of Nursing, confirmed that the transfer method of the resident and interventions for hygiene and grooming including mouth care were not documented in the plan of care for the resident.

The Director of Nursing, confirmed the home's expectation was that the care set out in the plan of care should be based on an assessment of the resident and the needs and preferences of that resident.[s. 6. (2)] (615)

4.The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident.

During staff interviews and a clinical record review, it was revealed that a Resident exhibited responsive behaviours.
The Resident was being followed by the Behavioural Support Ontario (BSO) team and Seniors Mental Health for ongoing responsive behaviours.

A review of the plan of care revealed there was no evidence that these responsive behaviours and interventions to manage the behaviours were documented.

During interviews, with the BSO representative and the RAI Coordinator, it was confirmed these behaviours and interventions to manage the identified behaviours were not documented in the plan of care, and acknowledged that the care set out in the plan of care should be based on an assessment of the resident and the needs and preferences of that resident.[s. 6. (2)] (137)

5.The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs change or care set out in the plan was no longer necessary.

A review of the plan of care in the clinical record of a Resident revealed a specific intervention for the prevention of falls. When asked, the resident indicated that she/he did not use the specific intervention identified in the plan of care.

In an interview with two Personal Support Workers and a registered staff, they acknowledged that the resident refused to use the specific intervention. They confirmed that the care set out in the Resident's plan of care was no longer necessary.

The Director of Nursing confirmed the home's expectation was that the resident should be reassessed and the plan of care reviewed and revised when care needs change.[s. 6. (10) (b)] (515)

6.The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs change or care set out in the plan was no longer necessary.

A review of the plan of care in the clinical record of a Resident indicated specific directions for staff to clean the resident's teeth.

In an interview and observation with the Resident, it was confirmed the resident did not have any teeth and had not had teeth for over a year.

In an interview with two Personal Support Workers, it was confirmed that the Resident did not have teeth, that the dentures broke over a year ago, and a review of the progress notes indicated the dentures broke on a specific date.

In an interview with the RAI Coordinator, it was revealed she was not aware that the resident did not have teeth and it was confirmed that the plan of care was not reviewed and revised when care needs changed. (615)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le :

Mar 31, 2016(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the Long-Term Care Homes Act, 2007, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la Loi de 2007 sur les foyers de soins de longue durée, L. O. 2007, chap. 8

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de sions de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 13 day of May 2016 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : HELENE DESABRAIS - (A1)

Service Area Office /
Bureau régional de services : London