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 soins 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
Sep 05, 2017;	2017_262630_0021 (A2)	018687-17	Resident Quality Inspection

Licensee/Titulaire de permis

CARESSANT-CARE NURSING AND RETIREMENT HOMES LIMITED
264 NORWICH AVENUE WOODSTOCK ON N4S 3V9

Long-Term Care Home/Foyer de soins de longue durée

CARESSANT CARE LISTOWEL NURSING HOME
710 RESERVE AVENUE SOUTH LISTOWEL ON N4W 2L1

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

AMIE GIBBS-WARD (630) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

This report was amended to allow for the Public Order report to be amended for the Immediate Order.

Issued on this 5 day of September 2017 (A2)

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

Original report signed by the inspector.

Ontario

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

AMIE GIBBS-WARD (630) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): August 21, 22, 23, 24, 25, 28, 29, 30 and 31, 2017.

The following concurrent inspections were conducted during the Resident Quality Inspection (RQI):

Critical Incident Log #018139-17 for Critical Incident System (CIS) report 2664-000013-17 related to a missing resident;

Critical Incident Log #019322-17 for Critical Incident System (CIS) report 2664-000015-17 related to a missing resident;

Critical Incident Log #020411-17 for Critical Incident System (CIS) report 2664-000016-17 related to a missing resident;

Complaint Log #035444-16/IL-48630-LO related to Infection Prevention and Control.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Activity Director, the Nutrition Manager, the Resident Assessment Instrument (RAI) Coordinator, the Registered Dietitian (RD), Environmental Supervisor, the Ward Clerk, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSWs), Housekeepers, a Dietary Aide, a Security Guard, family members and over forty residents.

The inspectors also observed resident rooms and common areas, observed medication storage areas, observed medication administration, observed meal and snack service, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home and reviewed various meeting minutes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Laundry

Continence Care and Bowel Management

Dining Observation

Falls Prevention

Family Council

Infection Prevention and Control

Medication

Minimizing of Restraining

Nutrition and Hydration

Pain

Personal Support Services

Residents' Council

Responsive Behaviours

Safe and Secure Home

Skin and Wound Care

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

7 WN(s)
5 VPC(s)
3 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. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

The licensee has failed to ensure that all doors leading to the outside of the home, other than doors leading to secure outside areas that precluded exit by a resident or doors that residents did not have access to, were i) kept closed and locked, ii) equipped with a door access control system that was kept on at all times, and iii) equipped with an audible door alarm that allowed calls to be cancelled only at the point of activation and that A. was connected to the resident-staff communication and response system or B. was connected to an audio visual enunciator that was connected to the nurses' station nearest to the door and had a manual reset switch at each door.

Multiple observations over the course of the inspection found that the door that led from the small dining room to the yard was unlocked, the door was not equipped with a door access control system that was kept on at all times and the door was not equipped with an audible door alarm or an audio visual enunciator. Observations also found that the fence had a sign on it that said “stop” and “do not climb the fence.” There were areas of the yard that could not be seen from inside the dining room due to trees or the building structure.

Multiple observations during the inspection found that residents were able to open the door from the dining room to the yard with no staff present.

During interviews with multiple staff during the inspection it was reported that the door that led from the small dining room to the yard was unlocked, the door was not equipped with a door access control system that was kept on at all times and the door was not equipped with an audible door alarm or an audio visual enunciator.

During interviews with the Administrator and Director of Care it was also reported that the door that led from the small dining room to the yard was unlocked, the door was not equipped with a door access control system that was kept on at all times and the door was not equipped with an audible door alarm or an audio visual enunciator. The Administrator and DOC acknowledged that there was risk related to the door.

Based on these observations, interviews and record review the licensee has failed to ensure that the door leading to the outside of the home was in compliance with the legislation.

The severity was determined to be a level four as there was immediate jeopardy/risk. The scope of this issue was widespread during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 9. (1) 1.]

Additional Required Actions:

CO # - 901 was served on the licensee. CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)The following order(s) have been amended:CO# 901

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

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; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

The licensee has failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at any time when the resident's care needs changed.

During the inspection an identified resident was observed at multiple meals being assisted with eating and drinking by staff. This identified resident was observed to be in a position that was different that the directions provided in the plan of care.

During interviews with multiple staff it was reported that the positioning needs of this identified resident had changed and this needed to be reassessed.

A review of the clinical record for the resident showed that the change in positioning of this resident had not been assessed at the time of the initial meal observation.

During an interview the Nutrition Manager said that this identified resident needed to be reassessed and the plan of care updated regarding positioning at meals.

During an interview the Director of Care said that this identified resident needed an assessment and the plan of care updated to reflect this resident's needs. [s. 6. (10) (b)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the care set out in the plan had not been effective.

Multiple Critical Incident System (CIS) reports were submitted to the Ministry of Health and Long Term Care (MOHLTC) from the home related to behaviours for an identified resident.

The clinical record for this identified resident showed that an assessment of specific behaviours had been completed on a specified date and interventions added to the plan of care.

Review of the clinical record for this identified resident showed that the specific behaviours had continued and that had placed the resident at risk. This clinical record showed that the interventions in the plan of care had not been reviewed and updated after incidents occurred related to the behaviours.

During the inspection this identified resident was observed with this specific behaviour.

During interviews with multiple staff during the inspection it was reported that this resident had specific behaviours and the interventions that were implemented in the home had not been effective.

During interviews with the Administrator and Director of Care it was reported that this resident had specific behaviours and it was acknowledged that the interventions that were implemented in the home had not been effective. They said it was the expectation in the home that the plan of care would reflect the interventions that had been implemented.

Based on these observations, interviews and clinical record review the home failed to ensure that this identified resident was reassessed and the plan of care reviewed and revised when the care set out in the plan had not been effective related to behaviours.

The severity was determined to be a level four as there was actual risk for harm. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on December 1, 2015, in Resident Quality Inspection (RQI) #2015_418615_0035 as a Compliance Order (CO), and this CO was complied on May 12, 2016, in Follow-up Inspection 2016_418615_0013. [s. 6. (10) (c)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system which used sound to alert staff, was properly calibrated so that the level of sound was audible to staff.

On multiple occasions during the inspection, the inspectors noted that the call bells could not be heard in the farthest one third of both the East and South hall resident

care areas. The call response system sound was made from the panel at the front desk and it was observed that there were no other locations in the care areas where the sound was made.

An identified staff member acknowledged that they were unable to hear the call bells at the farthest one third of the East and South hall and also acknowledged that if they were working in a resident room or down the opposite hallway and could not see the dome lights, they would not be aware that a resident had activated a call bell.
The Environmental Supervisor stated that they completed call bell audits quarterly that consisted of assessing the pull cord, activating all stations and ensuring that the call bell activation was showing on the panel at the nurse's station and that the call bell was ringing at the nurse's station. The Environmental Supervisor acknowledged that they did not check to see if they could hear the call bell in all care areas only at the nurse's station.

The Director of Care (DOC) acknowledged that the call bells could not be heard at the farthest one third of the hallways. The DOC stated it would be the expectation that the staff would be able to hear the call bells in all resident care areas.

The Administrator acknowledged that the call bells could not be heard at the farthest one third of the hallways and that they had been under the impression that the call bells were audible in all care areas.

Based on these observations and interviews the Licensee has failed to ensure that the resident-staff communication and response system was properly calibrated so that the level of sound was audible to staff.

The severity was determined to be a level two as there was potential for actual harm. The scope of this issue was widespread during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 17. (1) (g)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is equipped with a resident-staff communication and response system that in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that, a resident exhibiting altered skin integrity, including pressure ulcers, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A) Review of an identified resident's clinical record stated that the resident had developed an area of altered skin integrity. The inspector and an identified

registered staff member were unable to locate a skin and wound assessment in the clinical record.

The DOC acknowledged that the expectation of the home would be that any resident exhibiting alteration in skin integrity would have a skin and wound assessment as soon as possible, weekly and with any change. The DOC shared that the identified resident should have had a skin and wound assessment on the date the wound was noted.

B) On two specified dates, an identified resident told the inspector that they had a long standing area of altered skin integrity which had an impact on their mood, appetite and activity level. The identified resident could not recall exactly when this area of altered skin integrity developed.

On a specified date an identified registered staff member said that the identified resident had an area of altered skin integrity. The identified registered staff member said they completed initial wound assessments in the Pixalere software program for large areas of altered skin integrity. The identified registered staff member said that the initial altered skin integrity assessment that was completed for the identified resident was dated six days after a progress note referenced the area of altered skin integrity.

On a specified date the DOC said that their skin report for a specific month did not include the area of altered skin integrity of the identified resident. The DOC acknowledged that there was a progress note, which referenced a new area of altered skin integrity for the identified resident. The DOC said that they looked through the assessments in Pixalere and the first assessment for this area of altered skin integrity was five days after the area of altered skin integrity was identified in the progress notes. The DOC said it was the expectation in the home that this area of altered skin integrity would have been assessed when it was initially identified by staff using the assessment form in Pixalere.

The severity was determined to be a level two as there was potential for actual harm. The scope of this issue was a pattern during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 50. (2) (b) (i)]

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 a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a weight monitoring system to measure and record each resident's weight on admission and monthly thereafter.

Review of the clinical record for an identified resident stated a weight in April, two weights in May, and a weight in August, 2017. The inspector and Nutrition Manager were unable to locate any weights for the identified resident for June or July 2017.

The home's policy titled "Monthly Weights", last reviewed September, 2016 stated: "Resident's weights are to be taken monthly and recorded as an indicator that the resident's 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'.

The DOC acknowledged that the identified resident had not had a monthly weight completed for June or July 2017, and further acknowledged that the resident had experienced weight loss between May and August, 2017. The DOC stated that it would be the expectation of the home that all residents would be weighed at least monthly.

The Licensee has failed to ensure that the resident was weighed monthly.

The severity was determined to be a level two as there was potential for actual harm. The scope of this issue was isolated during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 68. (2) (e) (i)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Nutrition an Hydration program includes a weight monitoring system to measure and record with respect to each resident to measure weight on admission and monthly thereafter, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

Findings/Faits saillants :

The licensee has failed to ensure that the advice of the Residents' Council was sought in developing the satisfaction survey.

On a specified date an identified resident told the inspector that they were an active member of the Residents' Council in the home. The identified resident said they were aware that an annual satisfaction survey was completed in the home but they did not think that the Residents' Council had been involved in the development of the survey.

A review of the Residents' Council minutes for the past year found no reference to the licensee seeking the advice of the council on the development of the satisfaction survey.

On a specified date, the Activity Director told the inspector that the annual satisfaction survey was sent from the corporate office and the Resident's Council was not involved in developing the satisfaction survey.

On a specified date, the Administrator told the inspector that the annual satisfaction survey was developed corporately and the Resident's Council in this home was not involved in developing the satisfaction survey.

The severity was determined to be a level one as there was minimal risk for harm. The scope of this issue was widespread during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation.. [s. 85. (3)]

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 they seek the advice of the Residents' Council in developing the survey, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that: (a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed (b) corrective action is taken as necessary, and (c) a written record was kept of everything required under clauses (a) and (b).

Review of the home's medication incident reports for January, February and March 2017 stated that there were a total of three medication incidents during the quarter,

which included one near miss that did not reach the residents and two additional incidents involving the same resident. The inspector was unable to locate an analysis or any corrective actions taken for any of the three medication incidents reviewed.

The home's policy 9-1, titled "Medication Incident Reporting", last reviewed February 2017 stated “The Medication Incident Report is reviewed, analyzed and included in the evaluation at the home in order to reduce and prevent medication incidents and adverse drug reactions.

The Director of Care (DOC) acknowledged that the home was not completing an analysis or taking corrective action for all medication instances.

The Licensee has failed to ensure that all medication incidents and adverse drug reactions were reviewed and analyzed and corrective action was taken as necessary.

2. The licensee has failed to ensure that: (a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, (b) any changes an improvements identified in the review are implemented, and (c) a written record is kept of everything provided for in clause (a) and (b).

Review of the home’s Professional Advisory Committee (PAC) meeting dated May 2, 2017 showed three medication incidents for the quarter of January, February and March 2017. The inspector was unable to locate a quarterly review of the medication incidents.

The home's policy 9-1, titled "Medication Incident Reporting", last reviewed February 2017 stated “The consultant will report the consolidated reviews of the incidents with the Medication Safety team in the home and discuss the system/process improvements to avoid future incidents.”

The DOC acknowledged that the incidents were listed by the pharmacy at the PAC meetings however there was no review or analysis completed.

The Licensee has failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that have occurred in the home

since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, and any changes or improvements were identified and implemented.

The severity was determined to be a level two as there was minimal harm or potential for actual harm. The scope of this issue was widespread during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. [s. 135. (3)]

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 all medication incidents and adverse drug reactions are documented, reviewed and analyzed, corrective action is taken as necessary, and a written record is kept of everything required and as well as to ensure a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, any changes and improvements identified in the review are implemented, and a written record is kept of everything required, to be implemented voluntarily.

Issued on this 5 day of September 2017 (A2)

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

Long-Term Care Homes Division
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Name of Inspector (ID #) / Nom de l'inspecteur (No) : AMIE GIBBS-WARD (630) - (A2)

Inspection No. / No de l'inspection : 2017_262630_0021 (A2)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 018687-17 (A2)

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

Report Date(s) / Date(s) du Rapport : Sep 05, 2017;(A2)

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

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

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 : 901

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

(A1)
The licensee shall ensure that all doors leading to the outside of the home, other than doors that residents do not have access to, are kept closed and locked.

The licensee shall specifically ensure that the door leading from the small dining room to the yard, which is an outside area that does not preclude exit, is equipped with a lock system to allow it to be kept closed and locked.

The licensee shall ensure that the door leading from the small dining room to the outside yard area is kept closed and locked and that this can only be opened by staff and that the key is accessible to staff at all times.

The licensee shall ensure there is written communication that is posted and accessible to all staff and visitors identifying the need to keep the door locked.

The licensee shall provide written evidence that there is an authorized purchase order and plan in place to ensure that the door leading from the small dining room to the outside yard area, will be equipped with a door access control system that is kept on at all times and equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and is connected to the resident-staff communication and response system by September 13, 2017.

The licensee shall ensure that all residents do not have access to the door that leads to the outside of the home from the service hallway.

The licensee shall have interventions in place to ensure a specified resident does not exit the door leading from the small dining room to the yard, which is an outside area that does not preclude exit, without supervision.

Grounds / Motifs :

(A2)
1. The licensee has failed to ensure that all doors leading to the outside of the home, other than doors leading to secure outside areas that precluded exit by a resident or doors that residents did not have access to, were i) kept closed and locked, ii) equipped with a door access control system that was kept on at all times, and iii)

equipped with an audible door alarm that allowed calls to be cancelled only at the point of activation and that A. was connected to the resident-staff communication and response system or B. was connected to an audio visual enunciator that was connected to the nurses' station nearest to the door and had a manual reset switch at each door.

Multiple observations over the course of the inspection found that the door that led from the small dining room to the yard was unlocked, the door was not equipped with a door access control system that was kept on at all times and the door was not equipped with an audible door alarm or an audio visual enunciator. Observations also found that the fence had a sign on it that said “stop” and “do not climb the fence.” There were areas of the yard that could not be seen from inside the dining room due to trees or the building structure.

Multiple observations during the inspection found that residents were able to open the door from the dining room to the yard with no staff present.

During interviews with multiple staff during the inspection it was reported that the door that led from the small dining room to the yard was unlocked, the door was not equipped with a door access control system that was kept on at all times and the door was not equipped with an audible door alarm or an audio visual enunciator.

During interviews with the Administrator and Director of Care it was also reported that the door that led from the small dining room to the yard was unlocked, the door was not equipped with a door access control system that was kept on at all times and the door was not equipped with an audible door alarm or an audio visual enunciator. The Administrator and DOC acknowledged that there was risk related to the door.

Based on these observations, interviews and record review the licensee has failed to ensure that the door leading to the outside of the home was in compliance with the legislation.

The severity was determined to be a level four as there was immediate jeopardy/risk. The scope of this issue was widespread during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. (630)

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

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

Aug 31, 2017(A1)

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. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The licensee shall specifically ensure that the door leading from the small dining room to the yard, which is an outside area that does not preclude exit is:
i) kept closed and locked;
ii) equipped with a door access control system that is kept on at all times; and
iii) equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and is connected to the resident-staff communication and response system.

The licensee shall ensure that an identified resident does not exit the door leading from the small dining room to the yard which is an outside area that does not preclude exit, without supervision.

Grounds / Motifs :

1. The licensee has failed to ensure that all doors leading to the outside of the home, other than doors leading to secure outside areas that precluded exit by a resident or doors that residents did not have access to, were i) kept closed and locked, ii) equipped with a door access control system that was kept on at all times, and iii) equipped with an audible door alarm that allowed calls to be cancelled only at the point of activation and that A. was connected to the resident-staff communication and response system or B. was connected to an audio visual enunciator that was connected to the nurses' station nearest to the door and had a manual reset switch at each door.

Multiple observations over the course of the inspection found that the door that led from the small dining room to the yard was unlocked, the door was not equipped with a door access control system that was kept on at all times and the door was not equipped with an audible door alarm or an audio visual enunciator. Observations also found that the fence had a sign on it that said “stop” and “do not climb the fence.” There were areas of the yard that could not be seen from inside the dining room due to trees or the building structure.

Multiple observations during the inspection found that residents were able to open the door from the dining room to the yard with no staff present.

During interviews with multiple staff during the inspection it was reported that the

door that led from the small dining room to the yard was unlocked, the door was not equipped with a door access control system that was kept on at all times and the door was not equipped with an audible door alarm or an audio visual enunciator.

During interviews with the Administrator and Director of Care it was also reported that the door that led from the small dining room to the yard was unlocked, the door was not equipped with a door access control system that was kept on at all times and the door was not equipped with an audible door alarm or an audio visual enunciator. The Administrator and DOC acknowledged that there was risk related to the door.

Based on these observations, interviews and record review the licensee has failed to ensure that the door leading to the outside of the home was in compliance with the legislation.

The severity was determined to be a level four as there was immediate jeopardy/risk. The scope of this issue was widespread during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation (630)

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

Sep 15, 2017

Order # /
Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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).

Order / Ordre :

The licensee will ensure each resident is reassessed and the plan of care reviewed and revised at any time when the care set out in the plan had not been effective.

The licensee will also specifically ensure:
a) That an identified resident is reassessed and the interventions in the plan of care reviewed, revised and implemented related to behaviours. This will be done at any time when the care set out in the plan has not been effective. The effectiveness of the interventions in the the plan of care for this resident's behaviours will be monitored.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the care set out in the plan had not been effective.

Multiple Critical Incident System (CIS) reports were submitted to the Ministry of Health and Long Term Care (MOHLTC) from the home related to behaviours for an identified resident.

The clinical record for this identified resident showed that an assessment of specific behaviours had been completed on a specified date and interventions added to the plan of care.

Review of the clinical record for this identified resident showed that the specific behaviours had continued and that had placed the resident at risk. This clinical record showed that the interventions in the plan of care had not been reviewed and

updated after incidents occurred related to the behaviours.

During the inspection this identified resident was observed with this specific behaviour.

During interviews with multiple staff during the inspection it was reported that this resident had specific behaviours and the interventions that were implemented in the home had not been effective.

During interviews with the Administrator and Director of Care it was reported that this resident had specific behaviours and it was acknowledged that the interventions that were implemented in the home had not been effective. They said it was the expectation in the home that the plan of care would reflect the interventions that had been implemented.

Based on these observations, interviews and clinical record review the home failed to ensure that this identified resident was reassessed and the plan of care reviewed and revised when the care set out in the plan had not been effective related to behaviours.

The severity was determined to be a level four as there was actual risk for harm. The scope of this issue was isolated during the course of this inspection. There was a compliance history of this legislation being issued in the home on December 1, 2015, in Resident Quality Inspection (RQI) #2015_418615_0035 as a Compliance Order (CO), and this CO was complied on May 12, 2016, in Follow-up Inspection 2016_418615_0013. (630)

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

Oct 31, 2017

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

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 soins 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

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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 soins 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 5 day of September 2017 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : AMIE GIBBS-WARD - (A2)

Service Area Office /
Bureau régional de services : London